

A TRANSDISCIPLINARY APPROACH TO DEALING WITH CHILD OFFENDERS WITH
PSYCHIATRIC DISORDERS

by

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ABSTRACT

This study aimed to develop a framework for improved legislation, methods of practice and services used to meet the best interest of child offenders with psychiatric disorders within the South African child justice system. This aim was achieved via a qualitative study, which evaluated child justice and mental health legislation, methods of practice, role-players, and services in South Africa, and compared same to those in Namibia, Botswana, and Nigeria; to establish if the best interest of child offenders with psychiatric disorders are currently met from a South African perspective.

Data collection occurred in two phases: a document analysis of legislation, policies, and procedures in the selected comparative jurisdictions; followed by semi-structured interviews with child justice and mental health experts. During phase one the researcher analysed child justice and mental health legislation, human rights protections, and policy related to child justice in Nigeria, Botswana, Namibia, and South Africa. In addition, she interrogated literature relating to child justice and mental health, in comparative jurisdictions. This phase formed the foundation for the semi-structured interview schedule. Purposive and theoretical sampling was used to conduct 24 semi-structured interviews. Data was analysed and interpreted using pure qualitative document and thematic analysis.

The overarching findings indicate that the best interest of child offenders with psychiatric disorders, in the South African child justice system, are unprotected. This vulnerable group is not dealt with from an individualised, case-specific, multi-disciplinary perspective; informed by legislation, practice-policy, and a service-orientated approach. Further, certain domestic legislation and methods of practice are inadequate in holistically assessing a child who comes into conflict with the law in the jurisdictions of comparison.

Further findings identified that biological, psychological, environmental, cultural, and social factors influence the development of psychiatric disorders in children, which may bring them into conflict with the law. This study further confirmed that Attention Deficit Hyperactivity Disorder, Intellectual Development Disorder, Learning Disorder, Oppositional Defiant Disorder, and Conduct Disorder are prevalent in children who

come into conflict with the law. Further, substance abuse disorder, depression and attachment disorder were identified as predominant factors affecting children who come into conflict with the law. The influence of these factors, in conjunction with biological, psychological, environmental, cultural, and social factors, were found to predispose children to psychiatric disorders linked to criminal behaviour.

Thus, to meet the best interest standard; children in conflict with the law must be dealt with using a multi-factorial approach which considers biological, environmental, social, cultural, and psychological factors. In this way, the behaviour of child offenders with psychiatric disorders will be addressed holistically in a manner that considers all factors influencing behaviour. The empirical data supported the recommendations used to develop a trans-disciplinary framework for child offenders with psychiatric disorders.

KEY TERMS:

Child justice; child offenders; children in conflict with the law; psychiatric disorders; mental disorders; best interest standard; criminal capacity; multi-disciplinary; multi-dimensional; trans-disciplinary; neurodevelopmental; disruptive, impulse-control, and conduct disorders.

ISICATSHULWA

Olu phononongo lwesi sifundo lujolise ekuphuhliseni isakhelo somthetho ophuculiweyo, iindlela zokusebenza kunye neenkonzo ukwenzela ukunikezela ezona zilungileyo iimfuno zabantwana abangabaphuli-mthetho benengulo yesifo sengqondo kwinkqubo yobulungisa yabantwana eMzantsi Afrika. Le njongo yaphunyezwa ngokwenziwa kwezifundo ezisemgangathweni ezahlola umthetho wobulungisa kubantwana kunye nomthetho olawula ezempilo ngokwengqondo, iindlela zokusebenza, abathathi-nxaxheba kunye neenkonzo eMzantsi Afrika. Ezi zathi ngoko zathelekiswa nomthetho, umsebenzi abathathi-nxaxheba kunye neenkonzo eNamibia, eBotswana, kunye naseNigeria ukufumanisa ukuba iimfanelo ezizizo zabantwana abangabaphuli-mthetho abaneengxaki zengqondo bayanakekelwa ngoku eMzantsi Afrika.

Ukuqokelelwa kweenkcukacha kwenzeka kumanqanaba amabini: uhlalutyo lwemiqulu yomthetho, umgaqo-nkqubo kunye nenkqubo; Ukucacululwa kwamaxwebhu/kwemiqulu omthetho, umgaqo-nkqubo kunye neenkqubo ezikhethiweyo zothlekiso kulawulo lwezobulungisa, lilandelwe ludliwano-ndlebe olungahlelwanga ngokupheleleyo neengcaphephe/neengcali zezobulungisa lwabantwana kunye nemilo yezengqondo.

Kwinqanaba lokuqala umphandi ucazulule umthetho wobulungisa kubantwana kunye nempilo yezengqondo, ukhuseleko lwamalungelo oluntu.kunye nemigaqo-nkqubo ehambelana/ enxulumene nobulungisa kubantwana eNigeria, eBotswana, eNamibia naseMzantsi Afrika. Ukongezelela walugocagoca uncwadi olubhekisele kubulungisa babantwana nezempilo yezengqondo kulawulo lwezobulungisa Eli nqanaba libe sisiseko soludwe lwenkqubo yodliwano-ndlebe olungamiselwanga ngokupheleleyo.

Isampulu enenjongo neyingcingane yasetyenziswa ukuze kuqhutywe udliwano-ndlebe olungama-24 olungahlelwanga ngokupheleleyo. Ulwazi (*idata*) lwacacululwa lwacaciswa kusetyenziswa uxwebhu olusemgangathweni kunye nocalulo (*analysis*) olusemxholweni.

Iziphumo ezicacileyo/eziqaqambileyo eziluphahla zibonisa ukuba okukokona kulungele abantwana abangabaphuli-mthetho abaneengxaki zezengqondo, abakhuselekanga kwinkqubo yezobulungisa babantwana eMzantsi Afrika. Eli qela lingakhuselekanga alivelelwa ngokomntu neengxaki zakhe yedwa, ngokwengxaki yakhe ngokuthe ngqo kusetyenziswe indlela ezahlukeyo ezilawulwa ngumthetho, ngumgaqo-nkqubo osebenzayo nokuvelela ngendlela yokuziqhelanisa nemeko. Ukuya phambili, eminye yemithetho yasekhaya neendlela zokusebenza azonelanga ekuhloleni ngokupheleleyo kumntwana ohlangabezana nokuphikisana nomthetho kummandla wothelekiso.

Kuphinde kwafunyaniswa ukuba iimeko zozalo, zengqondo, zendawo, zenkcubeko nezentlalo ziyaziphembelela iingxaki zezengqondo ezivelayo ebantwaneni, ezinokwenza baphikisane nomthetho. Olu phononongo luqhubeka lungqina ukuba ukunganiki ngqalelo kwingxaki yokuphaphazela, ingxaki yokukhula kwengqiqo, ingxaki yokufunda, ingxaki yenkcaso yokulungileyo/ ukudelela kunye nengxaki yokuziphatha zixhaphakile kubantwana (abonayo) abaphikisana nomthetho. Ingxaki yokusebenzisa iziyobisi, incinezelo kunye nokuxhomekeka ziye zaphawulwa njengeemeko ezixhaphakileyo ezikhathaza abantwana abalwa nomthetho (abonayo). Iimpembelelo zezi meko, zidibene neemeko zozalo, zezengqondo, zendawo, zenkcubeko nezentlalo, zifunyenwe zilungiselela kwangaphambili abantwana kwezi ngxaki zezengqondo zithungelene ekuziphatheni ngokolwaphulo-mthetho.

Ngoko ke ukuhlangabezana nomgangatho ofanelekileyo nobalulekileyo, ebhekelela abantwana abaphikisana nomthetho (abonayo) makusetyenzwe ngabo kusetyenziswe indlela ejongene neemeko ezininzi ezibandakanya iimeko zozalo, zendawo, zentlalo, zenkcubeko kunye nezengqondo. Ngale ndlela abantwana abaphula umthetho abanengxaki yezengqondo baya kuncedwa ngokupheleleyo ngendlela ebandakanya zonke iimeko eziphembelela ukuziphatha. Idatha ekholose ngamava avela kumava nokuboniweyo ixhasa izindululo ezenziweyo zokumisa isakhelo esisebenza kulo lonke uqeqesho lomntwana ophikisana nomthetho (owonayo) onengxaki yezengqondo.

ISIGAMA ESINGUNDOQO:

Child justice; umthetho wobulungisa wabantwana

child offenders; abantwana abalwa nomthetho/abonayo

children in conflict with the law; abantwana abanenkcaso nomthetho

psychiatric disorders; izifo zengqondo;

mental disorders; ukuphazamiseka kwengqondo

best-interest standard; umgangatho onomdla kakhulu ongcono

criminal capacity; Amandla olwaphulo-mthetho/ubugebengu

multidisciplinary; izifundo ezahlukeneyo zoluleko ezininzi

multidimensional; okwamandla amaninzi okuziphindaphinda

transdisciplinary; okusebenza kuzo zonke izifundo zoluleko

neurodevelopmental; ekhulisa imithambo-luvo

disruptive-ephazamisayo

impulse-control ukwenza ngokungacingi

kunye

iingxaki zophazamiseko lokuziphatha

KAKARETSO

Patlisiso ena e reretswe ho hlahisa moralo wa molao o ntlafetseng, mekgwa ya tshebetso le ditshebeletso bakeng sa molemo wa batlodi ba molao bao e leng bana ba nang le mathata a kelello tshebeletsong ya toka ya bana Afrika Borwa. Morero ona o fihletswe ka boithuto ba boleng, bo lekantseng melao ya toka ya bana le ya bophelo bo botle ba kelello, mekgwa ya tshebetso, baamehi le ditshebeletso Afrika Borwa. Tsona di ile tsa bapiswa le melao, tshebetso, baamehi le ditshebeletso dinaheng tsa Namibia, Botswana le Nigeria ho fumana hore na melemo e loketseng ya batlodi ba molao bao e leng bana ba nang le mathata a kelello e ya fumaneha hajwale Afrika Borwa.

Pokeletso ya dintlha e etsahetse ka mekgahlelo e mmedi: manollo ya ditokomane tsa molao, melawana le mekgwatshebetso dibakeng tse kgethilweng tsa papiso tsa semolao; ho latetswe ke di-inthavu tse sa hlophiswang le ditsebi tsa toka ya bana le tsa molao wa bophelo bo botle ba kelello. Mokgahlelong wa pele mofuputsi o ile a manolla molao wa toka ya bana le wa bophelo bo botle ba kelello, ditshireletso tsa ditokelo tsa botho le melawana e amanang le toka ya bana dinaheng tsa Nigeria, Botswana, Namibia le South Africa. Ho feta moo, o ile a batlisisa dingolwa tse mabapi le toka ya bana le bophelo bo botle ba kelello dibakeng tse ka bapiswang tsa semolao. Mokgahlelo ona o bile motheo wa lenane la di-inthavu tse sa hlophiswang. Ho sebedisitswe mokgwa wa disampole wa kgetho le wa theho ya thiori ho etsa di-inthavu tse 24 tse sa hlophiswang. Dintlha di manollotswe le ho tolokwa ka manollo e sa tswakwang ya boleng ba ditokomane le ditema.

Diphetho tse akaretsang di supa hore melemo e nepahetseng ya batlodi ba molao bao e leng bana ba nang le mathata a kelello ha e ya sireletswa moralong wa toka ya bana wa Afrika Borwa. Sehlopha sena se kotsing ha se sebetswe ka tjhebo ya bo-motho ka mong, ya kgetsi e kgethehileng, ya mafapha a mangata e tshehedistsweng ke molao, molawana wa tshebetso le tjhebo ya tshebetso. Ho feta moo, melao e meng ya lehae le mekgwa ya tshebetso e ne e fokola bakeng sa ho lekola ngwana ka tsela e felletseng, ya iphumanang a le kgahlano le molao dibakeng tsa semolao tse neng di bapiswa.

Ho boetse ha fumanwa hore dintlha tsa tlhaho, kelello, tikoloho, setso le botjhaba di susumetso tlhaho ya bokudi ba kelello baneng, e leng ho etsang hore ba iphumane ba le kgahlano le molao. Boithuto bona hape bo tiisitse hore bokudi ba tlholeho ya tsepamiso le ketso e fetang tekano, bokudi ba kgolo ya bohlale, bokudi ba ho ithuta, bokudi ba ho ba kgahlano le ba bang le bokudi ba boitshwaro bo bongata bakeng ba iphumanang ba le kgahlano le molao. Bokudi ba tshebediso e mpe ya tahi kapa dithethefatsi, tshithabelo ya maikutlo le bokudi ba kgokahano di fumanwe e le mabaka a mantlha a amang bana ba qwaketsanang le molao. Tshusumetso ya dintlha tse, hammoho le dintlha tsa tlhaho, kelello, tikoloho, setso le botjhaba, di fumanwe e le hore di pepesa bana ho bokudi ba mafu a kelello a amanngwang le botlokotsebe.

Kahoo, e le ho ka fihlella maemo a melemo e nepahetseng, bana ba kgahlano le molao ba lokela ho sebetswa ka mokgwa wa ditsela tse fapaneng tse ngata, o kenyeletsang dintlha tsa tlhaho, tikoloho, setso, botjhaba le kelello. Ka mokgwa ona, batlodi ba molao bao e leng bana ba nang le bokudi ba kelello ba tla shejwa le ho sebetswa ka mokgwa o phethahetseng o kenyelletsang dintlha tsohle tse susumetsang boitshwaro. Dintlha tse bokelleditsweng di tsheheditse ditlahiso tse sebedisitsweng ho hlahisa moralo wa makala a fapaneng bakeng sa batlodi ba molao bao e leng bana ba nang le bokudi ba kelello.

KEY TERMS:

Toka ya bana; batlodi ba molao bao e leng bana; bana ba kgahlano le molao; bokudi ba kelello; mafu a kelello; maemo a melemo e nepahetseng; bokgoni ba botlokotsebe; ya makala a mangata; ya dintlha tse ngata; ya makala a kopaneng; kgolo ya kelello; e sitisang; bokudi ba tlhokeho ya taolo le boitshwaro.

DEDICATION

"In this life, we cannot do great things. We can only do small things with great love". (Mother Teresa[sa])

This thesis is dedicated to vulnerable, underprivileged, and victimised children, in South Africa, Africa and internationally. It is my hope that even the smallest efforts, such as this; may one day make a great contribution towards helping these children, who are products of our society.

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LIST OF ACRONYMS AND ABBREVIATIONS

Anti-social Personality Disorder	ASPD
Attention Deficit Hyperactivity Disorder	ADHD
Attention Deficit Hyperactivity Disorder South Africa	ADHDSA
Autism Spectrum Disorder	ASD
African Charter on the Rights and Welfare of the Child	ACRWC
Child and youth care centre	CYCC
Conduct Disorder	CD
Department of Correctional Services	DCS
Department of Education	DoE
Department of Health	DoH
Department of Justice and Constitutional Development	DOJ&CD
Department of Social Development	DSD
Diagnostic and Statistical Manual of Mental Disorders	DSM

Intellectual Development Disorder	IDD
Learning Disorder	LD
National Institute for Crime Prevention and the Reintegration of Offenders	NICRO
Non-governmental organisation	NGO
Oppositional Defiant Disorder	ODD
South African Police Service	SAPS
United Nations	UN
United Nations Convention on the Rights of the Child	UNCRC
United Nations International Children's Emergency Fund	UNICEF
University of South Africa	UNISA

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CHAPTER 1

ORIENTATION AND RESEARCH METHODOLOGY

1.1 INTRODUCTION

The incidence of children conflicting with the law is not only a South African concern but one experienced globally (Olashore, Ogunwale & Adebawale, 2016; Heita, 2015; Olashore, Frank-Hatitchi & Ogunwobi, 2017; Sommer, Hinsberger, Elbert, Holthausen, Kaminer, Seedat, Madikane & Weierstall, 2017; Paruk & Karim, 2016:548). Africa is not immune to child offending (Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al 2017; Paruk & Karim, 2016:548). Children residing in African countries, such as, for example, Nigeria, Botswana, Namibia, and South Africa, are exposed to socio-economic, biological, and environmental stressors on a multi-dimensional level (Olashore et al., 2016; Heita, 2015; Olashore et al, 2017; Sommer et al 2017; Paruk & Karim, 2016:548). Socio-economic, biological and environmental stressors, such as exposure to trauma, neglect, violence, child-maltreatment due to poverty and substance abuse are stressors which exacerbate a child's vulnerability to anti-social and problem behaviour, various learning, neurodevelopmental and disruptive, impulse-control, and conduct psychiatric disorders (Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017; Paruk & Karim, 2016:548; Pelsner, 2008:4; World Health Organisation, 2015:10). In the context of this research, the researcher posits that the above stressors increase the incidence of child offending and contribute thereto.

Considering a dearth of research, in child justice legislation and methods used to handle child offenders with psychiatric disorders, the purpose of this study was to make a recommendation for an improved trans-disciplinary framework to deal with this vulnerable group of children. To make this recommendation, the researcher commenced with an analysis of the causal risk factors associated with delinquency. A theoretical exploration of various criminological schools of thought, which explain causation of criminal behaviour linked to anti-social behaviour, follows thereafter.

The researcher explored the reciprocal causal nexus between delinquency and psychiatric disorders. To achieve same the researcher focused, as far as psychiatric disorders, on the Diagnostic Statistical Manual-5 (2013)¹ and the International Classification of Diseases² which form the primary manuals used to diagnose mental disorders.

This study focuses on children with psychiatric disorders who are in conflict with the law as a sub-group of vulnerable children within child justice in general. The focus centres on the best interest standard and its practical application to child offenders with psychiatric disorders. Child offenders within the context of this study, refer to child offenders suffering from a psychiatric disorder(s).

Contextually, the research rationale, motivation, and problem statement are discussed, below, followed by the methodology employed in this study. A discussion of ethical considerations and an outline of the research report concludes this chapter.

1.2 RESEARCH PROBLEM AND RATIONALE

The motivation for this study emanated from the findings of the researcher's master's study, which focused on the influence of psychiatric disorder(s) on the determination of the criminal capacity of child offenders between 10 and 14 years of age (Geoffrey, 2016). This study thus builds upon and extends the findings made thereby exploring how children (those at or below the age of 18 years) suffering from a psychiatric disorder(s), who conflict with the law are dealt with by the Child Justice Act 75 of 2008.³ This is an especially critical area of exploration considered against the rate of incidence of psychiatric disorder(s) in the childhood population of South Africa and related regional jurisdictions.

The South African Depression and Anxiety Group (2016:01) indicate that 17 per cent of children in South Africa suffer from mental disabilities. Stancheva (2017:1) demonstrated that one-in-ten, 5 to 17-year olds are affected by psychiatric disorder(s), with re-occurrence and persistence into adulthood. Research identifies

¹ Diagnostic Statistical Manual-5 (hereafter referred to as the DSM-5) (2013).

² International Classification of Diseases (hereafter referred to as the ICD-10) (2015).

³ Hereinafter referred to as the Child Justice Act.

neurodevelopmental disorders, such as attention deficit hyperactivity disorder (ADHD), learning disorders (LD), intellectual developmental disability (IDD) and disruptive, impulse-control, and conduct disorders, such as oppositional defiant disorder (ODD) and conduct disorder (CD), as the most common psychiatric disorders affecting children. These disorders are often compounded by and comorbid with socio-economic paucity (Coker, Smith, Westphal, Zonana, & Mcknee, 2014:888-898; Grisso, 2008:148; Murphey, Barry & Vaughn, 2013:4; Swanepoel, 2015:3238; Geoffrey, 2016:167; Stancheva, 2017:1).

Children with a psychiatric disorder(s) who are in conflict with the law are recognised as a vulnerable group, requiring specialised intervention and treatment (Underwood & Washington, 2016:228; Breen, 2011:6-7; Geoffrey, 2016: 172-173; National Instruction 2 of 2010, Children in conflict with the law, 2010, S2;). The pre-disposing causative risks associated with criminality and psychiatric disorder are multi-dimensional. Hence, a single-dimensional approach, focused on biological causes, the influence of a psychiatric disorder(s) or environmental causes exclusively. Resultantly it does not holistically address all factors influencing a child and is therefore insufficient to fully explain, and ultimately treat, a child offender with a psychiatric disorder. Ergo, to provide effective treatment to a child, it is essential to take a holistic, integrated approach to deal with children suffering from a psychiatric disorder(s) who conflict with the law. The suggested approach is currently lacking which will be demonstrated by this research.

Applying proper and effective legislation and methods of practice are essential to ensure that the best interest of child offenders suffering from a psychiatric disorder(s), is upheld. According to Geoffrey (2016:173-174), the South African child justice system is mired in legislative and operational challenges. These challenges include, but are not limited to, a lack of child justice legislation specific to child offenders suffering from a psychiatric disorder(s), and a lack of specialised services for this vulnerable sub-group of child offenders (Geoffrey, 2016:173-174; Human, 2015:102

Challenges experienced by child offenders suffering from a psychiatric disorder(s) are global (Olashore et al., 2016; Heita, 2015; Olashore et al, 2017; Sommer et al 2017; Paruk & Karim, 2016:548). Children residing in Nigeria, Botswana, Namibia,

and South Africa, are challenged by socio-economic and environmental difficulties,⁴ which predispose them to psychiatric disorder(s), anti-social and criminal behaviour (Bella, Atilola & Omigbodun, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016: 168-169). Although this study focusses on the South African situation, the researcher analysed the protection of the best interest standard, from both a legislative and practice-driven perspective, in Nigeria, Botswana, and Namibia. The comparative approach allowed the researcher to identify how child offenders suffering from a psychiatric disorder(s) are approached in other jurisdictions, which may be useful to the South African context.

The child justice process, specific to child offenders suffering from a psychiatric disorder(s), was juxtaposed to the constitutional best interest standard and provided the foundation for the recommendation of an improved trans-disciplinary framework in this field.⁵

Geoffrey (2016:171) identified limitations in South African legislation and methods applied to child offenders suffering from a psychiatric disorder(s), specific to the criminal capacity of offenders between 10 and 14 years of age. These findings concurred with Olashore et al (2016:1), Sommer et al (2017:29-34), Paruk and Karim (2016:548), Bhoge et al (2017: 192), Gaete, Labbe, Devillar, Allende, Araya and Valenzuela (2017:7-8) and Breen (2011:6-7), who confirmed that psychiatric disorders increase susceptibility to criminal behaviour. Hence it emphasised the urgency to develop assessments, treatment protocols and services that cater for the special needs, and uphold the best interest, of this vulnerable group. The processes and role-players involved in assessing children in conflict with the law and used to determine the influence of a psychiatric disorder on behaviour ⁶ are similar in Nigeria, Botswana, Namibia, and South Africa. Thus, the selected countries may present with similar inadequacies, or perhaps best practices for assessing and processing child offenders suffering from a psychiatric disorder(s). Therefore, based

⁴ Refer to chapter 2, for a detailed discussion on factors influencing the development of psychiatric disorders and criminal behaviour.

⁵ Refer to chapter 6, for key findings and the trans-disciplinary framework that should be used to deal with child offenders suffering from psychiatric disorders.

⁶ Refer to chapter 4, for a detailed discussion on the legislative process and role-players involved in dealing with child offenders with psychiatric disorders in the selected African countries.

on research findings, this study will focus on a trans-disciplinary approach to dealing with child offenders with psychiatric disorders.

Psychiatric disorders influence and affect child offenders during the pre-trial, trial, and post-trial phase of the criminal justice process (Karels & Pienaar, 2015:61; Swanepoel, 2015:3243, 3251). Delving into the treatment of such children (during all phases of the formal process and after-care) is a complex and multi-faceted task. Suitable and effective legislation and methods to deal with child offenders suffering from a psychiatric disorder(s) are vital to ensure that adequate consideration is granted to the special needs of this group (Karels & Pienaar, 2015:61; Swanepoel, 2015:3243, 3251; Breen, 2011:6-7). It is important to pay attention to the impact of childhood psychiatric disorder(s) and to focus on how the child justice system deals with such children who come into conflict with the law. To determine the degree to which South African legislation, policy, and practice ensure the best interest of child offenders suffering from a psychiatric disorder(s), this study examines the limitations of existing South African legislation and juxtaposes it against similar legislation in the selected jurisdictions of comparison.

Previous literature has identified the following lacunae in South African legislation and methods of practice, and therein highlighted the problem areas that will be further explored in this study:

- **Existing legislation, policy and practice does not adequately address proof of criminal capacity in respect of child offenders suffering from a psychiatric disorder(s)**

The Child Justice Act (Department of Justice and Constitutional Development [DOJ&CD], 2010a) does not contain a specific legislative provision addressing criminal capacity procedures for child offenders suffering from a psychiatric disorder(s). Instead, these children are referred to the authority of the adult in accordance to the Criminal Procedure Act 51 of 1977 (section 77-79).⁷

Human (2015:112), Pillay and Willows (2014:6), Karels and Pienaar (2015:66) and Geoffrey (2016:88-92) indicate that child justice legislation used to determine the

⁷ Criminal Procedure Act 51 of 1977 (hereafter referred to as the Criminal Procedure Act).

criminal capacity child offenders suffering from psychiatric disorder(s), is inadequate in holistically assessing the impact of the disorder(s) on a child's ability to appreciate the wrongfulness of his or her ⁸ behaviour and to act in accordance with that understanding. Furthermore, Karels and Pienaar (2015:60-61) raise concern as to whether the application of section 77 to 78 of the Criminal Procedure Act, is in the best interest of a child offender.

- **Current assessment procedures and tools applied to child offenders suffering from a psychiatric disorder(s) do not serve the child's best interest**

Human (2015:112) and Geoffrey (2016:167-171) highlighted a lack of standardisation of assessment procedures and tools used to deal with children who come into conflict with the law. Professionals who interact with children in conflict with the law often adopt different, single-dimensional approaches which do not holistically assess all factors that could influence a child's behaviour. In this respect, legislative and procedural ambiguities, identified in the Child Justice Act, reflect limited protective measures upholding the rights and best interest of child offenders suffering from a psychiatric disorder(s).

- **Limitations in facilities, services, and service-providers specialising in child offenders with a psychiatric disorder(s)**

The researcher argues that a shortage of facilities, services, and role-players involved in child justice proceedings, affect the reliability of assessments, criminal capacity procedures and the quality of services carried out in a child's best interest (Human, 2015:112; Geoffrey, 2016:171). Hence, the lack of after-care, namely addressing primary factors that initially pre-disposed the child to criminal behaviour; and risk factors for re-offending, are major areas of concern in long-term rehabilitation and reduction of criminal behaviour by young offenders. These factors all relate to (in)adequate implementation/protection of the constitutional best interest standard in South Africa.

⁸ For ease of reading the masculine personal pronoun is used in this study but infers both genders as the case may be.

- **Lack of research specifically relating to child offenders suffering from a psychiatric disorder(s)**

Badenhorst (2011), Walker (2011), Skelton (2013) and Schoeman (2016) address criminal capacity issues with reference to child justice legislation, such as the Children's Act 38 of 2008⁹ (DOJ&CD, 2005) and the Child Justice Act. Boezaart and Skelton (2011), Breen (2011), Karels and Pienaar (2015), Pillay and Willows (2015) and Geoffrey (2016) also refer to the Children's Act, Child Justice Act, and the Criminal Procedure Act in relation to the criminal capacity of child offenders with a psychiatric disorder(s). The latter bodies of research analyse the influence of environmental and societal factors and the impact of the psychiatric disorder on a child's behaviour. Specific attention is drawn to the impact of the disorder on a child's ability to appreciate the wrongfulness of actions and to act in accordance with that understanding. These bodies of research make a substantial contribution to the knowledge-base of child justice legislation pertaining to criminal capacity and the mental health of children in conflict with the law. The authors further supply an overview of internal and external factors that predispose children to conflict with the law, which is relevant to the criminal capacity assessment.

Although the research mentioned above makes a significant contribution, none provide a holistic legislative evaluation of the methods and practices applied to child offenders suffering from a psychiatric disorder(s), and the services available to address their unique needs.

Africa-based research¹⁰ supports the notion that psychiatric disorders are a risk factor for the development of criminal behavior (Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al 2017; Paruk & Karim, 2016:548). Indeed, the criminal capacity and mental health of child offenders has attracted a great deal of research attention (Breen, 2011:7; DOJ&CD, 2015:1). However, there is a dearth of research from a South African criminological perspective, which provides a trans-disciplinary approach to child offenders suffering from a psychiatric disorder(s).

⁹ Children's Act 38 of 2008 (hereafter referred to as the Children's Act).
¹⁰ As discussed above and in detail in chapter 3 and 4 of this study.

The aim of this study was to develop an improved, trans-disciplinary framework to holistically address child offenders with psychiatric disorders. To reach the research aim, and address the gap identified in child justice research, the researcher conducted an analysis of relevant legislation, methods, practices, and role-players involved with child offenders with psychiatric disorders, in Nigeria, Botswana, Namibia, and South Africa.

The value of this study and its research contribution are discussed below.

1.3. RESEARCH CONTRIBUTION

The value of this research lies in its proposed amendments to the existing framework applied to child offenders suffering from a psychiatric disorder(s). The researcher envisions the following research contributions:

1.3.1 Proposed amendments to the current framework used to deal with child offenders with psychiatric disorders

A framework is defined as a basic structure underlying a system or concept. It is an overview of interlinking structures which support a specific objective. As such, it serves as an operational and functional guide that can be amended (Yahya, Walters & Wills, 2016:1).

The purpose of a framework is to organise and supply structure to a body of knowledge by highlighting and explaining the relationship between the different components in the framework (Beard 2002:47). Since a framework serves as an operational and functional guide, the purpose and application of a framework, in the context of this study, allowed the researcher to gain a detailed understanding of the existing relationship between child justice legislation, and methods of practice. In addition it assisted to decipher if and how, the existing legislative and practical framework, meet the best interest of child offenders suffering from psychiatric disorder(s). In order to explore the relationship between child justice and mental health legislation, and the protection of the best interest standard, various facets were explored and analysed. These included the preambles, intentions, and objectives of the legislation and instruments applied to child offenders with psychiatric disorders. Furthermore, expert medical, psychological, legal, and criminological opinions, experiences and recommendations were explored.

Against the background of empirical data regarding the phenomenon of child offenders with psychiatric disorders, inadequacies and ambiguities were identified in the existing legislative and practical framework presently used to deal with this group of children in the child justice system. Based thereon, this study proposes amendments to the existing legislative and practical framework,¹¹ by recommending that child offenders' with psychiatric disorders are dealt with from a multi-inter-transdisciplinary perspective, in order to serve and protect the best interest standard.

1.3.2 Proposed improvement to services

This study evaluated whether adequate services are available to child offenders with psychiatric disorders from a practical perspective.¹² The preamble to the Children's Act and Child Justice Act acknowledge the special needs of children, including children in conflict with the law, and stipulate that in all matters, the best interest of the child is paramount. Providing fair and just practice, legislative procedures, and services to child offenders, especially child offenders who suffer from psychiatric disorders, is, therefore, a legislative obligation.

The scarcity of research which evaluates the practices applied to child offenders with psychiatric disorders was identified as a lacuna. Against this background, the aim of this study is to contribute to the knowledge-base of child justice and mental health for child offenders suffering from a psychiatric disorder(s). This goal will be pursued to ensure that children in conflict with the law and who suffer from a psychiatric disorder are dealt with in a fair and sensitive manner that upholds their rights and acts in their best interest.

1.3.3 Contributing to the knowledge-base

This study is multi-inter-transdisciplinary and therefore refers to child justice, law, criminology, psychology, and sociology precisely because causative factors and causal risk factors which influence childhood offending are multi-dimensional.

¹¹ This fulfils the purpose of a framework in terms of exploring the existing phenomenon and thus proposing amendments.

¹² Section 28 of the Constitution of the Republic of South Africa, 1996 (hereinafter referred to as the Constitution) section 11 of the Children's Act and section 3(h), 35 and 50 of the Child Justice Act stipulate that services delivered to a child offender should take the circumstances of the child, as well as the circumstances under which the alleged offence was committed, into consideration.

There is limited research on the legislative framework and practice used to deal with children with psychiatric disorders. Exploring and analysing the methods and legislative framework applicable to child offenders with a psychiatric disorder and proposing amendments that act in the best interest of the child, make a trans-disciplinary contribution to all child justice practitioners. Thus, although this study is criminological in nature, its multi-factorial scope intends to contribute to legal, psychological, sociological, criminological, and academic fields relating to child justice. Using this approach, the researcher intends to make a research contribution to child justice practitioners which include, but are not limited to, psychologists, psychiatrists, legal representatives, probation officers, social workers, police officials, and criminologists. The researcher further intends this research to raise awareness and contribute to an improvement of policy and practice applied to child offenders suffering from a psychiatric disorder(s).

From a logistical perspective, the researcher has elected to use both in-text and footnote referencing in-line with the multi-inter-transdisciplinary nature of the research. While this approach is unconventional, it aims to ease reading and contextualisation without detracting from the overall flow of the document.

1.4 RESEARCH AIM AND OBJECTIVES

According to Fouché and Delport (2011b:108), the purpose of research is to identify and explain particular issues which the researcher proposes to examine. The aim of this research was to propose amendments, in the form of a trans-disciplinary framework, for children in conflict with the law. To reach the research aim, the following objectives were identified:

- Analyse child justice legislation applicable to child offenders suffering from a psychiatric disorder(s).
- Explore psychiatric disorders and the influence thereof on the criminal behaviour of children
- Explore causal risk factors influencing psychiatric disorder(s) in child offenders.

- Analyse the availability of services to child offenders with psychiatric disorders.
- Establish if the best interest standard for child offenders with psychiatric disorders is met by current legislation and practice.

To meet the research aim, and address the objectives, research questions were identified. Doody & Bailey (2014:22) posit that the role of the research question is to direct and guide the intended study. The following research questions were formulated:

- What influence do environmental, social, cultural, psychological, and biological factors have on a child's brain development, behaviour and pre-disposition to crime?
- Are the current South African child justice legislative interventions and methods of practice effective in holistically addressing child offenders with psychiatric disorders?
- What causative influence, if any, do psychiatric disorders, such as ADHD, IDD, LD, ODD and CD, have on the propensity towards criminal behaviour in children?
- What is the availability and efficacy of legislation and methods of practice directed at offenders with psychiatric disorders?
- Is the best interest standard adequately met when dealing with child offenders with psychiatric disorders in South Africa?

1.5 DEFINITION OF KEY CONCEPTS

1.5.1 Child

Constitutionally (section 28(3)), and according to section 1 of the Child Justice Act, a child is defined as a person 18 years of age and younger. This definition is accepted by the researcher and used within the context of this study.

1.5.2 Children in conflict with the law

The phrase 'children in conflict with the law' refers to persons younger than 18 years of age, who come into contact with the criminal justice system as a result of being accused or suspected of having infringed upon the law (DOJ&CD, 2010b; National Instruction 2 of 2010, Children in conflict with the law, 2010, section 2). In many international laws, the term used to refer to a child in conflict with the law is juvenile or juvenile delinquent (Badenhorst, 2011:1). In South Africa, these terms are however considered as having a negative connotation and are therefore not used. The preferred phrase used to refer to a child who is suspected, or accused of a criminal offence, is a child in conflict with the law or child offender (Badenhorst, 2011:1).

Since this study focuses on child offenders suffering from a psychiatric disorder(s); children in conflict with the law and child offender will include and refer to child offenders with a psychiatric disorder(s).

1.5.3 Criminal capacity

Criminal capacity refers to the ability to appreciate the wrongfulness of an act and the ability to act in accordance with that understanding (Snyman, 2014:162-169). Determining criminal capacity of a child in conflict with the law involves determining, through means of a cognitive, psychological, emotional, moral and social assessment, if the child has the requisite ability to distinguish between right and wrong and to act in accordance with that understanding, at the time the offence was committed (Child Justice Act, section 11).

1.5.4 Best interest standard

According to the South African Constitution (section 28(2)), the child's best interest should be of paramount importance in all matters concerning the child. The meaning and interpretation of the best interest standard are explored in chapter 4.

In addition to constitutionally defining the best interest standard, the Children's Act (section 7(1)), outlines that the best interest standard refers to upholding particular aspects pertaining to a child's well-being. In terms of section 7(1) these factors include: nature of personal relationships, attitude of parents/or relevant caregivers, the ability of parents/caregivers to provide stability for the child's emotional and

intellectual needs and age, maturity, gender, background, physical, emotional, social, intellectual, cultural security, and development. In addition, factors pertaining to possible disabilities, illness, protection from maltreatment, abuse, violence, neglect, exploitation and degrading treatment are included (Children's Act, section 7(1)).

In terms of creating a criteria upon which the best interest of the child should be determined, the United Nations Committee on the Rights of the Child, in General Comment No. 2 (2014:49) eludes that the determination of the best interest standard includes a detailed, clear, comprehensive assessment which considers factors such as inter alia protection needs, vulnerabilities, and background.

Since the focus of this study is child offenders with psychiatric disorders particular attention will be drawn to the best interest standard, in relation to the child's emotional, intellectual and social development, and protection from maltreatment, abuse, and neglect, since research identifies these as particular factors which influence child offenders with psychiatric disorders.¹³

In the context of this study, the best interest of child offenders with psychiatric disorders is deemed to include the application of legislative and practical frameworks which take into consideration the influence of psychiatric disorders, the child's vulnerabilities, and psychological, emotional, social, and environmental development in relation to chronological age.

1.5.5 Psychiatric disorders

Mental disorder, mental illness, and psychiatric disorder will be referred to interchangeably in this study. The DSM-5 (2013: 20) defines a mental disorder as a significant impairment in one's cognitive and emotional regulation reflected as a dysfunction in the psychological, biological, and/or developmental process of mental functioning. It is of significance to emphasise that, although the ICD-10 (2015) is an international diagnostic manual it does not provide a definition of mental illness or psychiatric disorder. Furthermore, the Mental Health Care Act (17 of 2002)¹⁴ fails to clearly define psychiatric disorder and leaves the interpretation to mental health care

¹³ In chapter 4 the researcher fully analyses the meaning and judicial interpretation of the best interest standard.

¹⁴ Hereinafter referred to as the Mental Health Care Act.

practitioners. Issues in this regard are explored in detail in the contents of this study.¹⁵

Stein, Phillips, Bolton, Fulford, Sadler, and Kendler (2010:1762-1763) describe a psychiatric disorder as:

“...clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom”.

The American Psychiatric Association (2018:1) defines mental illness as conditions which cause an emotional and/or behavioural disturbance in one’s functioning. Symptoms or behavioural patterns resulting from a mental disorder should be considered a reflection of behavioural, psychological and/or biological dysfunction that is associated with a psychiatric disorder and not a manifestation of an expectable and culturally sanctioned response; such as the reaction to a death of a loved one or political, religious and/or sexually deviant behaviour (Stein et al, 2010:1763).

The DSM-5 (2013:31,461) categorises psychiatric disorders based on the manifestation, cause, and symptoms of a disorder. The researcher focused here¹⁶ on psychiatric disorders categorised under neurodevelopmental psychiatric disorders; to wit ADHD, LD and IDD; and disruptive, impulse-control, and conduct psychiatric disorders, namely ODD and CD.¹⁷

In the context of this study, the researcher posits that the definition outlined in the DSM-5 (2013) will suffice as the defining concept for psychiatric disorders in child offenders since this is the primary manual used by mental health practitioners from an international perspective.

¹⁵ Refer to chapter 3 and chapter 4, for a detailed discussion about issues in legislative terminologies.

¹⁶ In chapter 2 the researcher fully explores the identified psychiatric disorders and extrapolates their effect on criminal behaviour.

¹⁷ ADHD (attention deficit hyperactivity disorder); LD (learning disorder); IDD (intellectual developmental disorder); ODD (oppositional defiant disorder); CD (conduct disorder).

1.5.6 Trans-disciplinary

Alonge, Frattaroli, Davey-Rothwell and Baral (2016:127-136) define trans-disciplinary as a research approach in which persons from a range of different disciplines or professions, who have a shared interest, attempt to work jointly to address a specific problem or create a new concept from a combination of their disciplines. This approach is considered a more holistic and multi-dimensional approach to addressing specific social problems.

In addition to a trans-disciplinary approach, a multi-inter-transdisciplinary approach refers to a multi-dimensional group of role-players integrated from various sectors (Stock & Burton, 2011:1094). In the context of dealing with child offenders with psychiatric disorders, a multi-inter-transdisciplinary approach includes child justice and mental health experts who have interrelated and integrated common goals towards dealing with child offenders with psychiatric disorders.

In the context of this study, trans-disciplinary refers to an approach whereby various child justice and mental health experts, more specifically legal practitioners, probation officers, psychologists, psychiatrists, criminologists, and academics, are used to holistically address legislation and methods of practice used to address children with psychiatric disorders who are in conflict with the law.¹⁸

1.6 METHODOLOGICAL FOUNDATION

The methodological foundation of a study encompasses the procedures and instruments used during the execution of a research investigation (Fouché & De Vos, 2011:94; Leedy & Ormrod, 2014:141). Here, the research aim, objectives and questions are linked to the data and supply validation for the research instruments and techniques used. The methodology of a study is outlined in the research design and includes the research paradigm, goal, purpose, and approach used to achieve the anticipated outcome (Fouché & De Vos, 2011:94; Leedy & Ormrod, 2014:141).

1.6.1 Research paradigm

Research paradigm refers to the conceptual lens, practical pattern, structure, and framework on which the researcher bases the methodological foundation and data

¹⁸ Refer to chapter 3 for a detailed discussion pertaining child justice practitioners who deal with child offenders with psychiatric disorders.

analysis of a proposed study (De Vos, Strydom, Schulze & Patel, 2011:6-8; Chilisa & Kawulich, 2012:1). An interpretive approach, also referred to as the phenomenological paradigm, will be adopted in this study. According to De Vos, Strydom, Schulze, and Patel (2011:3) and Al-Saadi (2014:6), the interpretive approach adopts a philosophy which focuses on the interpretation and understanding of human behaviour and delves into a deeper understanding of a research problem. According to Al Saadi (2014:6), interpretivism is closely related to the Hermeneutic approach.

This approach is commonly used in qualitative research. It adopts multiple methods of data collection to gain insight into the focus of interest pertaining to the kind of issues people are faced with and the means by which to deal with them. Although the aim of this study is to develop a trans-disciplinary framework to address the inadequacies found in child justice legislation and practice; it acknowledges and identifies risk and causative factors linked to the development of psychiatric disorders and criminal behaviour. Thus, identifying issues facing children with the intent to propose a means by which this group of children can be dealt with. In addition, this study adopts multiple data collection methods, by employing a document analysis, and semi-structured subject expert interviews.

1.6.2 Research purpose

A research purpose can be either basic or applied in nature. Applied research provides resolutions useful in solving specific research problems (Fouche' & De Vos, 2011:94). This research goal is valuable in the field of criminal justice since it supplies practical solutions to ineffective policy and procedural frameworks (Dantzker & Hunter, 2011:10). In contrast, basic research forms a foundation and produces new knowledge (Fouche' & De Vos, 2011:94). This research purpose does not offer speedy resolutions to research problems within the discipline but is considered more consistent with criminological scholarly development and inquiry (Dantzker & Hunter, 2011:10).

An analysis of the legislative framework, methods of practice and subsequent proposed amendments as they apply to child offenders with psychiatric disorders, adopt an applied research purpose. Thus, this study will address deficiencies in current policy and practice by proposing amendments to the current framework used

to deal with child offenders with psychiatric disorders. An exploration of these methods and legislative and procedural challenges could be beneficial as it will add to the knowledge-base of child justice and mental health experts. The development of a trans-disciplinary framework and proposed amendments aim to improve practical and legislative processes, criminal capacity assessment, methods of ensuring the best interest standard, and services available to child offenders with psychiatric disorders.

1.6.3 Research goal

The purpose of inquiry can be characterised by adopting an exploratory, explanatory, descriptive or evaluative research goal (Fouche' & De Vos, 2011:94). Since limited research has been conducted on the practice and applicability of current legislation used to deal with a child offender with a psychiatric disorder; the exploratory and descriptive research goal was identified as most appropriate for this study.

According to Van Wyk (2012:8) and Rieter (2017:135), exploratory research is most suitable to gain insight into a topic which lacks basic information and to understand the cause and effect of aspects within the research phenomenon. Although research¹⁹ has been conducted on the nexus between psychiatric disorders and criminal behaviour, the formers influence on problem behaviour in children, and associated child justice and mental health challenges, have not been identified and explored.

Whilst exploratory research will provide vital legislative factors that should be used to deal with a child offender with a psychiatric disorder, from child justice and mental health experts, it is essential to also propose amendments based on the identified inadequacies found in child justice and mental health legislation applicable to child offenders with psychiatric disorders. Thus, this study not only adopts an exploratory research goal, due to the limited knowledge identified but also a descriptive research goal. According to Fouche' and De Vos (2011:94), descriptive research offers deeper meaning in specific situations and supplies insight into the 'how' and 'why' questions

¹⁹ Refer to chapter 2, for the casual link between psychiatric disorders and criminal behaviour for children in conflict with the law. Refer to chapter 3 for a detailed literature review on psychiatric disorders and the nexus between psychiatric disorders and criminal behaviour in children. Refer to chapter 4 for a comparative analysis of child justice legislation in the selected African countries which deal with child offenders with psychiatric disorders.

of a phenomenon. In this study, it was important to explore if the present legislation and methods of practice uphold the best interest of a child offender with a psychiatric disorder and to delve deeper into the means by which improvements can be made. Employing both the exploratory and descriptive research goal allowed the researcher to propose amendments through the development of a trans-disciplinary framework, focused on the best interest standard which can be used to deal with child offenders with psychiatric disorders.²⁰ The findings from this study add to the knowledge-base and propose amendments in terms of the legislation and practice applied to children with psychiatric disorders in conflict with the law.

1.6.4 Research approach

The three approaches to conduct scientific research include qualitative, quantitative or a mixed-methods approach (Fouche' & Delport, 2011a:63; Leedy & Ormrod, 2014:141). The qualitative research approach was identified as most suitable to meet the aims and objectives of this study. Qualitative research is an inductive, naturalistic, and representative research approach (Leedy & Ormrod, 2014:141). It focuses on fewer individuals and investigates behaviour, attitudes, experiences, and social issues of a specific phenomenon (Creswell, 2014:37). The qualitative research approach was most beneficial since it provided an in-depth perspective on the research problem and allowed for a multiple-data-collection-methods approach.

In other words, with the intent of developing a framework which can be applied to child offenders suffering from a psychiatric disorder(s); the qualitative research approach provided an insider's view of the existing framework and proposed amendments by focusing on and interpreting the opinions and experiences of child justice experts. In this light, the qualitative approach allowed data collection via a two-phase sequential process, using a purely qualitative approach.

1.6.5 Unit of analysis

Unit of analysis refers to specific features, or elements of the sample and social context, in which the data is collected, defined, and explained (Creswell, 2014:38-39; Khan, 2014:228). Since the unit of analysis informs the 'what', 'who' and 'where' of the study, it should be clear and unambiguous in delimitating and identifying the

²⁰ Refer to chapter 6 for legislative and methods of practice recommendations.

scope of the study. In other words, the unit of analysis can be defined as the aspects that inform the intentions of the research study.

This study focused on establishing the nexus between the concept psychiatric disorder and criminal behaviour in children. The study asks; how do psychiatric disorders influence criminal behaviour and the criminal capacity of a child and how does criminal behaviour link to psychiatric disorders. It furthermore questions the effectiveness of legislation used to deal with children with psychiatric disorders who are in conflict with the law. With this focus in mind, children suffering from neurodevelopmental and disruptive, impulse-control, and conduct disorders were the focus of this study. Since this study approaches the phenomenon from a legal and psychiatric perspective, one needs to take into consideration the context in which the child conflicts with the law, and the after-care system for child offenders to prevent re-offending.

The researcher explored and analysed three child justice focus areas to wit:

1. National and international human rights instruments on the best interest standard, the rights of children with special needs, such as mental disabilities, and factors defining a child as one in need of care and protection in the countries of comparison.
2. The legislation and methods used to deal with child offenders with psychiatric disorders. The legislative analysis was conducted on the nature and scope of child justice laws pertaining to the determination of criminal capacity for child offenders with psychiatric disorders, the mental capacity to understand proceedings and criminal responsibility based on the defence of mental defect or mental illness.
3. The evaluation of practice: the assessment process, role-players, facilities, services and if, and to what extent, the best interest standard is upheld for this vulnerable group of child offenders.

The unit of analysis in this study included child justice and mental health experts from governmental, non-governmental and private sectors that were suitably qualified and involved in child justice procedures and child offenders with psychiatric

disorders. This included psychologists, psychiatrists, social workers, probation officers, legal representatives, criminologists, and academics who share expertise in dealing with this vulnerable group of children. In addition, the child justice and mental health legislative framework, presently used to deal with child offenders with psychiatric disorders, as informed by the Constitution, Children's Act, Child Justice Act, Criminal Procedure Act, and Mental Health Care Act, also formed the unit of analysis. Additionally, a comparative analysis was conducted of the child justice and mental health legislation used in Namibia, Botswana, and Nigeria. These countries were selected since literature identified similarities in child justice legislation and methods of practice, as well as in the environmental and socio-economic factors between Nigeria (Bella et al, 2010:1; Olashore et al, 2016), Namibia (Heita, 2015), Botswana (Olashore et al, 2017) and South Africa (Sommer et al, 2017:29-34; Paruk & Karim, 2016:548-550). Although the select African countries formed the basis for the legislative analysis, the focus centred on South African methods of practice. Therefore, the child justice and mental health experts targeted were South African and recruited nationally. Against the background of the researcher's master's study,²¹ the child justice and mental health experts as identified formed the basis of the sample for data collection.

1.6.6 Sample design

Sampling refers to the process by which the researcher makes an observation of a reduced portion or unit and is thus able to reflect what can be expected in the total population (Strydom, 2011c:228). In other words, sampling refers to the process by which a portion of the population is selected (Rahi, 2017:5).

Probability and non-probability sampling are the two predominant sampling methods used in research (Strydom, 2011c:228). Rossouw (2003:113-114) posits that qualitative sampling is more reliant on non-probability sampling techniques; which include purposive, theoretical, deviant case, sequential, snowball, key informant, and volunteer sampling.

A non-probability sequential sampling method, relying on purposive and snowball sampling techniques, was used in this study. Data were collected in two phases namely document analysis (phase 1) and semi-structured interviews (phase 2). The

²¹ Refer to Geoffrey (2016:16-17) for unit of analysis which formed the basis of that study.

application of sequential purposive and snowball sampling used in the study is discussed below.

- **Purposive sampling**

Purposive sampling, also referred to as judgemental sampling, is used to gain evidence-rich data wherein the researcher is able to identify specific individuals who are especially knowledgeable about a particular research phenomenon, to serve the research purpose (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015:533-544; Alvi, 2016:300).

In this study, the first phase of data collection commenced with purposive sampling. Here, document analysis of international human rights conventions and child justice legislation was undertaken in order to establish the existing framework for dealing with child offenders with psychiatric disorders. The following human rights instruments, child justice, and mental health legislation were included in the study, and only legislative factors specific to child offenders with psychiatric disorders were explored.

➤ ***International human right instruments:***

- The United Nations Convention on the Rights of the Child (UNCRC, 1990).²²
- The UN²³ Rules for the protection of Juveniles Deprived of their Liberty (1990).
- The UN Standard Minimum Rules for the Administration of Juvenile Justice (1985) (Beijing).²⁴
- The UN Guidelines for the Prevention of Juvenile Delinquency (1990B), also referred to as the 'Riyadh Guidelines'.²⁵

²² The United Nation (UN) Convention on the Rights of the Child (1990) [hereafter referred to as the UN Convention on the Rights of the Child or the UNCRC] (1990).

²³ United Nations [hereafter referred to as UN]

²⁴ The UN Standard Minimum Rules for the Administration of Juvenile Justice (1985) [hereafter referred to as the Beijing Rules] (1985).

²⁵ The UN Guidelines for the Prevention of Juvenile Delinquency (1990) [Hereafter referred to as the 'Riyadh Guidelines'] (1980).

- African Charter on the Rights and Welfare of the Child (1990).²⁶
- The UN Convention on the Rights of Persons with Mental Disabilities (2007).²⁷

➤ ***Domestic legislation:***

- The Constitution of the Republic of South Africa, 1996.²⁸
- The South African Children's Act 38 of 2005.²⁹
- The South African Child Justice Act 75 of 2008.³⁰
- The South African Criminal Procedure Act 51 of 1977.
- The South African Mental Health Care Act 17 of 2002.

➤ ***Legislation in jurisdictions of comparison***

- The Constitution of the Federal Republic of Botswana of 2006.³¹
- The Children's Act of 2009.
- The Botswana Penal Code of 1964.
- The Botswana Mental Disorders Act of 1961.
- The Constitution of the Federal Republic of Nigeria of 1999.³²
- The Nigerian Children's Rights Act of 2005.³³

²⁶ The African Charter on the Rights and Welfare of the Child (1990) [hereafter referred to as the ACRWC] (1990).

²⁷ The UN Convention on the Rights of Persons with Mental Disabilities (2007) [hereafter referred to as UNCRPD] (2007).

²⁸ The Constitution of the Republic of South Africa, 1996 [hereafter referred to as the South African Constitution or the Constitution of South Africa].

²⁹ The South African Children's Act 38 of 2005 [hereafter referred to as the Children's Act].

³⁰ The South African Child Justice Act 75 of 2008 [hereafter referred to as the Child Justice Act].

³¹ The Constitution of the Federal Republic of Botswana of 2006 [hereafter referred to as the Botswana Constitution]

³² The Constitution of the Federal Republic of Nigeria of 1999 [hereafter referred to as the Nigerian Constitution].

- The Children and Young Persons' law of Nigeria of 1990.

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- The Nigerian Criminal Code (1916).
- Nigerian Penal Code (1960).
- The Lunacy Act (1958).
- The Constitution of the Republic of Namibia of 1998.
- The Namibian Child Care and Protection Act of 2015.
- The Namibian Mental Health Act 18 of 1973 (RSA).³⁵

Furthermore, against the background of the researchers' master's study, child justice and mental health experts who have specific skills in child justice and mental health for children were identified and formed the basis of the sample. Further to this, experts in the field of child justice and mental health in South Africa were also identified during the literature reviews, based on their expert research contribution to child justice and mental health for children. Thus, child justice and mental health experts who demonstrated the most characteristics and attributes relevant to the focus areas of the study were selected (Strydom and Delport, 2011:392). Expert personal information was found in the public domain and they were contacted and recruited via e-mail and telephonically.³⁶

- **Snowball sampling**

Snowball, also referred to as 'chain-referral' sampling, is used when there are limitations to primary data and/or appropriate participants are difficult to find (Alvi, 2016:33). This sampling method is based on referrals from primary participants nominating other potential participants for data collection, thus creating a chain referral (Alvi, 2016:33).

³³ The Nigerian Children's Rights Act of 2005 [hereafter referred to as the Children's Act in the context of Nigeria].

³⁴ The Children and Young Persons' law of Nigeria of 1990 [hereafter referred to as the Children and Young Persons' law of Nigeria].

³⁵ The Namibian Mental Health Act 18 of 1973 (RSA) [hereafter referred to as the Mental Health Act of Namibia].

³⁶ The demographic analysis of the participants is included in chapter 5.

The second phase of sampling incorporated snowball sampling due to limitations identified in obtaining an adequate number of child justice and mental health experts. Thus, to obtain an adequate amount of evidence-rich data, participants referred the researcher to other potential child justice and mental health experts using snowball sampling, to gain a more detailed understanding of the research topic (Strydom & Delport, 2011:392). Limitations caused by perceived restrictions on governmental participants were particularly noted in the case of social workers and probation officers. These professionals were reluctant to participate in the study, despite assurances regarding anonymity and non-association with place or organisation of employment.

Since qualitative research places emphasis on collecting detailed, in-depth information from participants until a point of saturation; Palinkas et al (2015:533-544) are of the opinion that there is no exact sample size. Thus, the sample size in this study was dependent on obtaining an adequate amount of data in terms of the research inquiry and was pursued until a point of saturation was reached. In this study, the sample consisted of 24 child justice and mental health experts; namely two psychiatrists (participants 2 & 17); five psychologists (participants 3, 7, 10, 13, 21); two advocates (participant 4 & 12); one social worker participant 16), one probation officer (participant 5), 3 probation officer supervisors (participant 8, 9, 11) and ten academics (participant 1, 6, 14, 15, 18, 19, 20, 22, 23, 24). As demonstrated above, although social workers and probation officers are two of the major role-players in the child justice process, the representative sample in this group was limited due to a lack of willingness to participate.

1.6.7 Data collection

The data collection process in qualitative research offers multiple methods of gathering information. These include participant observation, interviews, document analysis and literature reviews (Strydom, 2011c:330; Greef, 2011: 342; Strydom & Delport, 2011:377).

In qualitative research, data collection may be an intertwined process which employs flexible procedures for analysing data and developing a theoretical model from the interpreted data (Leedy & Ormrod, 2011:141-142). In this study, the data collection

process was conducted in two sequential phases; namely document analysis and semi-structured interviews, as discussed below.

- **Phase One: Document analysis**

The data collection process in this study was referred to as sequential since the first phase, namely document analysis, informed the second phase, namely semi-structured interviews. According to Strydom and Delport (2011:376) a document study - or as referred to in this study, a document analysis - is the process of delving deeper into existing literature and interpreting information to obtain a deeper meaning therefrom for scientific research.

In this study, a document analysis focused on international human rights instruments, legislative frameworks, and procedures, with a holistic focus on the best interest of child offenders with psychiatric disorders. In addition, research studies and official documentation concerning child justice, criminal capacity and mental health-related issues were explored.

Literature from the document study formed the basis and informed the development of the semi-structured interview schedule, which guided the second phase of the study to wit interviews with child justice and mental health experts.³⁷ According to Bowen (2017:1), in order to create credibility, and to ensure that the research phenomena reaches convergence, a corroboration of data sources should be used. For example, in addition to the document analysis, the researcher employed semi-structured interviews with child justice and mental health experts. The process by which a researcher adopts multiple sources of sequential data collection is referred to as triangulation which improves the validity, credibility, and reliability of a study (Leedy & Ormrod, 2014:153).

- **Phase Two: Semi-structured interviews**

Semi-structured interviews were conducted with 24 child justice and mental health experts; namely 2 face-to-face interviews and 22 telephonic interviews. The utilisation of telephonic interviews provided the advantage that the study could be conducted nationally, at the convenience of the experts' schedule. The interview

³⁷ Refer to Annexure C for semi-structured interview schedule.

schedule included 27 open-ended questions which facilitated data collection and each participant was interviewed once for approximately 30-40 minutes.

Conducting interviews allowed the researcher to gain an in-depth and holistic view of the research phenomena (Delpont & Roestenburg, 2011:200). Conducting semi-structured interviews allowed the researcher to gather focused, in-depth textual information, whilst still allowing flexibility for participants and the freedom to venture into topics relevant to the study, but which may not have been mentioned by the researcher (Delpont & Roestenburg, 2011:200). This method of data collection was considered beneficial since the research was exploratory and descriptive in nature and thus aimed to gather evidence-rich data from child justice and mental health experts regarding the existing framework, which served to inform the proposed amendments to deal with child offenders with psychiatric disorders.

The advantage of employing a document analysis as a means of data collection in this study is that it provided the researcher with an in-depth understanding of the present child justice and mental health legislation and practical methods used to deal with child offenders with psychiatric disorders, from an official governmental website. This method of data collection was beneficial since it was low cost, as all documentation was available in the public domain (O'Leary, 2014:130).

Because this study focused on legal, medical, and academic experts; questions were formulated to cater for the specific person within their profession but were stated in a manner that could be applied to all practitioners who deal with child offenders with psychiatric disorders.

The semi-structured interviews were audio recorded with the permission of the participants; thereby allowing the researcher to review each interview during the data analysis and interpretation process.

1.6.8 Data analysis and interpretation

A qualitative approach was followed in the data analysis and interpretation for the study. According to Schurink, Fouché and De Vos (2011: 397), the process of data analysis involves converting data into research findings. This involves reducing the amount of data, by identifying significant patterns and constructing a framework which communicates the essence of what the data has revealed. Unique to data

analysis and interpretation in this study was the qualitative techniques for document analysis and the thematic analysis process as explored below (Javadi & Zarea, 2016:33; Alhojailan, 2012:42; Strydom & Delport, 2011:380).

- **Phase One: document analysis**

In phase one of this study, documents were analysed to create context and analyse meaning in terms of applicability to dealing with child offenders with psychiatric disorders. Strydom and Delport (2011: 380) and Bowen (2017:1) posit that document analysis is the process of systematically reviewing documents to interpret, elicit meaning, gain understanding and develop empirical knowledge. The flexible and practical steps which applied to the document analyse in this study are explored below in terms of the guidelines by Strydom and Delport (2011: 380) and Bowen (2017:1).

- ***Formulation of the initial research question***

The research question was identified and focused on whether the best interest of child offenders with psychiatric disorders are met/supported in terms of legislation, methods, and services currently available. This formed the base and informed the study in terms of the research aim and objectives.

- ***Obtain sources and develop an archive for documents***

International human rights instruments, child justice and mental health legislation, case files and academic literature research specific to children, child offenders and child offenders with psychiatric disorders, were explored.

- ***Critical reading and interrogation***

During this step, human rights instruments, legislation, case files, and academic literature was reviewed in order to create context and gain a deeper understanding of the legislative and practical issues in child justice and mental health, which affect child offenders with psychiatric disorders.

➤ ***Coding and analysis***

During the coding phase, human rights instruments, child justice, and mental health legislation and academic literature were explored and compared in Nigeria, Botswana, Namibia, and South Africa. Here, themes which focused on the nexus between psychiatric disorders and criminal behaviour; the adequacy of child justice and mental health legislation; services available and the best interest standard were identified. The themes and findings from the literature reviews, in chapter 2 and 3, as well as the document analysis in chapter 4, informed the development of the semi-structured interviews.

➤ ***Writing- up and producing the report***

Chapter 4 presented a write-up of the comparative legislative analysis of child justice and mental health for children in the jurisdictions of comparison. Here, the researcher's interpretation of the adequacy of legislation was presented in terms of meeting the best interest of the child. The purpose of the comparative analysis was to compare South African legislation with her regional counterparts and thereafter identify best practices which may be included in the proposed South African amendments.

The document analysis was followed by the thematic data analysis, namely semi-structured interviews, as discussed below.

• **Phase Two: Thematic data analysis**

During the second phase of data analysis, a thematic analysis was employed to analyse and interpret data collected from the semi-structured interviews. This process involves identification, analysis, and reporting of patterns and themes which emerged from the data. Thematic data analysis is a common form of data analysis in qualitative research and involves six basic steps to reduce data in order to produce evidence-rich, detailed data from the semi-structured interviews.

There are six different approaches in thematic data analysis, namely the inductive, deductive, semantic, latent, realistic and constructionist approach (Javadi & Zarea, 2016:33). The inductive thematic analysis approach focuses on the coding and

themes which emerge and develop from the raw data. In the context of this study, themes which emerged from the child justice and mental health practitioners pertaining to the legislation and methods of practise used to deal with child offenders with psychiatric disorders were explored and provided guidelines for recommendations that were made in the conclusion of this study. Based on the principle of being grounded in the content of the data, this approach was employed as the most beneficial thematic analysis approach for this study (Javadi & Zarea, 2016:33; Alhojailan, 2012:42). These steps, as determined by guidelines provided by Javadi and Zarea (2016:33) and Alhojailan (2012:42) are discussed below.

➤ ***Familiarisation with the data***

In the first phase of thematic analysis, the interviews which were conducted with child justice and mental health experts were audio-recorded. This allowed the researcher to transcribe the data into manageable units. The transcribed data was explored in-depth so as to encourage immersion and familiarity with the content. This step provided for subsequent data analysis which was further explored during the coding phase discussed below.

➤ ***Coding***

During the coding phase of thematic analysis, connections and key features were identified in the participant's feedback in terms of the nexus between psychiatric disorders and criminal behaviour, adequacy of child justice and mental health legislation, services available to child offenders and how these factors influenced the best interest standard for a child in conflict with the law. A coding scheme was created in terms of feedback from the participants.

➤ ***Searching for themes***

During this phase, the researcher began interpreting and analysing the coded information. Here, similarities and differences in expert opinions emerged, relevant overarching themes surfaced, and relationships between codes and sub-themes were identified. In terms of this study, the overarching themes which were identified are discussed in detail in chapter 6.

➤ **Reviewing, defining, and naming themes**

The reviewing, defining, and naming phase is a two-step process which was combined in the data analysis process (Javadi & Zarea, 2016:33; Braun & Clarke, 2016:16). During this phase, identified themes were further refined, grouped, and named, which informed the essence of the data in terms of writing-up of the proposed legislative and practical amendments.

Pertinent points made by the experts captured the essence and focus areas of the study; which were quoted in the report to substantiate the findings presented. Since the information collected during the document analysis formed the guidelines for the semi-structured interview schedule; themes, which emerged during the document analysis, were constantly compared for similarities and differences, against the emergent interview themes and are explored in chapter 5 and 6 of the study.

➤ **Writing up and producing the report**

The last step in data analysis involved the corroboration of information and the researcher's interpretation of the emergent themes which were applied to the research aim, objectives, and questions. The process of thematic analysis in this study was spiral since data analysis moved between phases as data was refined. The findings from the data analysis centred on the best interest standard for child offenders with psychiatric disorders as presented in chapter 5 and 6.

1.7 VALIDITY AND RELIABILITY

Quality assurance, or assuring validity and reliability, is important in any scientific research. Validity refers to whether the research instrument effectively measures the concept it is designed to measure, while, reliability refers to the level of consistency and ability of the research instrument to replicate results (Rossouw, 2003:180). According to research (Davies Francis, & Jubb, 2011:355), to assure the quality of a study it is imperative to evaluate the trustworthiness.

1.7.1 Triangulation

Data triangulation in qualitative research refers to using multiple data collection sources to develop a comprehensive, convergent, and in-depth understanding of a research phenomenon (Leedy & Ormrod, 2014:153; Carter, Bryant-Lukosius,

Dicenso, Blythe & Neville, 2014:545-547). According to Carter et al (2014:545-547), the four basic types of triangulation include data triangulation, investigator triangulation, theory triangulation and methodological triangulation. Since this study adopted multiple data collection sources - document analysis and semi-structured interviews - the methodological triangulation technique was applied. Further to the triangulation between the data collection tools, cross-referencing was conducted on information from child justice experts and compared from participant to participant. The sequential approach adopted in terms of the data collection tools -document analysis and semi-structured interviews - was beneficial in increasing the validity, reliability and understanding of the research phenomenon.

1.8 RESEARCH ETHICS

The protection and well-being of participants in social research are paramount and researchers are obliged to uphold ethical principles to ensure the protection of human subjects (Van Den Hoonaard & Van Den Hoonaard, 2013:23). The aforesaid three basic ethical principles comprise of respect for persons, beneficence and justice (Strydom, 2011a:113; Belmont Report, 1987:4-9). Factors such as avoidance of harm, voluntary participation, informed consent, privacy, and confidentiality, non-deception of subjects and assessment of risk-benefits are encompassed under these basic ethical principles.

1.8.1 Respect for persons

Respect for persons is one of the fundamental ethical principles documented in the Belmont Report (1979:4-7). To adhere to the ethical concern of 'respect for persons', it is vital to address issues relating to autonomy.

Interviews were conducted with subject specialists. Informed consent, including the right to voluntarily participate and the right to remain anonymous or waive such anonymity; was used to inform participants of their rights and obligations prior to interview commencement (Belmont Report, 1979:4-7). Interviews were audio-recorded, with the permission of participants. Audio-records and transcriptions were stored electronically under an alias file name, and a back-up of this information was saved on a hard drive wherein the data was anonymised to prevent the identification of participants.

1.8.2 Beneficence

Beneficence refers to the ethical principle of doing no harm as reflected in the Belmont Report (1979:4-7). Under this ethical principle, researchers are obliged to maximise the benefit and minimise potential risk to the participant. The ethical standards of privacy, anonymity, confidentiality, and minimising potential risk are intricately linked and often overlap between the process of 'respect for persons' and 'beneficence' (Belmont Report, 1979:4-7). As mentioned, participants were informed of their rights, such as the right to voluntarily participate, and the level of privacy, confidentiality, and anonymity. Documents analysed in this study are available in the public domain and therefore did not incur any risk in the first phase of data collection.

Based on the nature of the research topic, information collected dealt with participant perception within a professional environment concerning the current framework. Thus, no personal information of a sensitive nature was collected. Information disclosed during interviews remained confidential when the analysed data was interpreted and categorised as indicated in earlier discussions. Participant feedback was grouped and identified using labels and unique numbers. In addition, in order to ensure protection and respect for particular opinions expressed in chapter 5, data was anonymised.

1.8.3 Justice

Under the final ethical standard, the emphasis is placed on fairness in terms of the selection of research participants (Belmont Report, 1979:8-9). Participants should be identified and selected for participation based on the aim, objectives and outcomes of the study, and the researcher should take caution in only approaching potential participants who share attributes relevant to the study.

It must be further acknowledged that, due to the nature of this study, it was considered to be a low-risk study. The data collected focussed on participants' professional opinions, hence no information of a personal nature was collected. In the context of this study, child justice and mental health experts were selected based on their level of expertise and experience of dealing with child offenders with psychiatric disorders in the child justice and mental health sector.

1.9 LIMITATIONS OF THE STUDY

- **Lack of previous research**

The primary limitation identified in this study was the lack of previous research which focused on the best interest of child offenders with psychiatric disorders in South Africa. Although there are various bodies of literature which focus on children in conflict with the law, children with psychiatric disorders, and the nexus between psychiatric disorder and criminal behaviour; there is a paucity of research focused on the best interests of child offenders with psychiatric disorders.

- **Researcher's experience**

In terms of dealing with the child, child offenders and children with psychiatric disorders; the researcher holds academic qualifications in psychology and criminology, with a master's degree in Criminal Justice (specialising in criminal capacity matters for child offenders with psychiatric disorders). Further to academic experience, the researcher also holds work experience dealing with and treating special needs children suffering from psychiatric disorders.

In addition to the aforementioned limitation pertaining to a lack of research, the researcher acknowledges that this study adopted a criminological perspective and does not attempt to provide an expert psychological or legal perspective. However, in cognisance of this, the study aimed to overcome this limitation by incorporating a broad scope of child justice and mental health experts from a legal and psychological sector.

1.10 LAYOUT OF THESIS

Chapter 2: A theoretical analysis of the nexus between criminal behaviour and psychiatric disorders in children

In chapter 2 the researcher presents the causative factors for psychiatric disorders, problem behaviour and criminal behaviour. Criminological theoretical underpinnings, used to explain the causation of criminal behaviour in child offenders with psychiatric disorders, is further therein explored. Here, an integrated, holistic perspective is adopted.

Chapter 3: Dealing with child offenders with psychiatric disorders

In the contents of chapter 3 the researcher analyses and explores the DSM-5 (2013) and ICD-10 (2015) and their categorisation of prevalent psychiatric disorders found to influence child offenders. This chapter concludes with a discussion of the concept of mental illness or psychiatric disorder, from a legal and clinical perspective and discusses how these perspectives influence child offenders in the child justice system.

Chapter 4: An analysis of international treaties and domestic legislation pertinent to child offenders with psychiatric disorders in selected African countries

This chapter presents an analysis of documentation, such as legislation, national and international human rights instruments, and research studies pertaining to the procedural mechanisms and practices used to deal with child offenders with psychiatric disorders. Findings from the documentary analysis are presented in this chapter and applied to the best interest standard for child offenders with psychiatric disorders. This chapter concludes with a comparative analysis of the best interest standard for child offenders in the jurisdictions of comparison. As mentioned, themes and categories identified under the document analysis formed the focus area for data collection in the interviews.

Chapter 5: Presentation of findings

In chapter 5, findings from interviews with child justice and mental health experts are presented.

Chapter 6: Conclusions: a transdisciplinary framework for dealing with child offenders with psychiatric disorders

Chapter 6 presents a proposed legislative framework that can be used to deal with South African child offenders with psychiatric disorders, from a holistic, integrated, trans-disciplinary, criminological perspective.

1.11 CONCLUSION

The purpose of this chapter was to orientate the reader to the research problem and rationale underpinning the study. The methodological approach was outlined to demonstrate the scientific validity and reliability of the study. In the next chapter, the causal link between delinquency and psychiatric disorders will be explored.

CHAPTER 2

A THEORETICAL ANALYSIS OF THE NEXUS BETWEEN CRIMINAL BEHAVIOUR AND PSYCHIATRIC DISORDERS IN CHILDREN

2.1 INTRODUCTION

The aim of this chapter is to explore the nexus between criminal behaviour and psychiatric disorders in children. Research has identified a causal link between bio-psycho-social functioning and criminal behaviour in children (Neuman, 2015:1; World Health Organisation, 2015:1; Pelser, 2008, Cortina, Sodha & Fazel, 2012: 276-281; Trollope, 2014:1; Ntsabo, 2018:1; Geoffrey, 2016:111, Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017:29-34; Paruk & Karim, 2016:548-550).

The causal link is not based on a singular factor but is an amalgamation of multi-dimensional factors which affect both the development of psychiatric disorders and criminal behaviour in children. Based on the multi-factorial approach¹ adopted in this study, an integrated theoretical approach was selected to explore the causal link between psychiatric disorders and criminality. The integrated theories selected are based on their multi-factorial, integrated principles; which take into consideration environmental, biological, psychological, social, and genetic factors to explain the causation of both psychiatric disorders and criminal behaviour, and the nexus between the two.

The selected theories include dual taxonomy, biosocial, somatic marker hypothesis, and the general strain theory. To substantiate the underpinnings of the integrated theoretical models selected in this study, it is vital to delve into the factors which cause and pre-dispose children to the development of both psychiatric disorders and criminal behaviour. Causative factors, for the development of psychiatric disorders, and the link to criminal behaviour, are of relevance here since they determine the process by which a child offender should be assisted in the child justice process, to

¹ Refer to chapter 2, for the casual link between psychiatric disorders and criminal behaviour; refer to chapter 3, for the prevalence of psychiatric disorders in child offenders with psychiatric disorders; refer to chapter 3, pertaining to the influence of psychiatric disorders influence of psychiatric disorders on children who enter the child justice system.

ensure the best interest standard. This chapter begins with an exploration of factors which contribute to the causal link in both psychiatric disorders and criminal behaviour. This is followed by an integrated theoretical exploration of the posited theoretical link(s).

2.2 THE CAUSAL LINK BETWEEN PSYCHIATRIC DISORDERS AND CRIMINAL BEHAVIOUR IN CHILDREN

Psychiatric disorders do not occur suddenly or unexpectedly; but surface gradually, resulting from changes in an individual's socio-cultural, biological, and psychological surroundings (Austin, Bezuidenhout, Botha, Du Plessis, Du Plessis, Jordaan, Lake, Moletsane, Nel, Pillay, Ure, Visser, Von Krosgigk & Vorster, 2014:501). Further, psychiatric disorders are not the result of a singular psycho-social, environmental factor but result from the amalgamation of various factors that contribute to the development and manifestation of psychiatric disorders and criminal behaviour. In this section, specific attention is given to the role of biological, psychological, and environmental factors in the causation of psychiatric disorders in children. The same factors predispose children to delinquency and thus, within the context of this study, both causal risk factors must be emphasised when dealing with child offenders with psychiatric disorders.

Approximately 75 per cent of South Africans suffer from mental illness and 20 per cent of South African children suffer from psychiatric disorders as a result of disrupted family environments and violence (Lund, 2018:1; Van Der Merwe, 2015:1). The problem is not limited to South Africa but is also experienced in many African countries, such as Nigeria, Botswana, and Namibia (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550).

As outlined above, it is essential to address the causative factors which contribute to the development of psychiatric disorders and criminal behaviour. In the context of this chapter, the biological, genetic, psychological, and environmental factors that influence mental health, and the development of criminal behaviour in children, are discussed.

2.2.1 Biological factors

Biological factors found to influence the development of psychiatric disorders are linked to abnormal functioning of the brain (Bhandari, 2016:1). Common causes of abnormal brain functioning include abnormalities in nerve-cell circuits or pathways, defects and/or trauma caused through injury (Shroff, 2016:1; Bhandari, 2016:1).

Abnormal functioning of nerve-cell circuits is linked to an imbalance of chemicals in the brain, called neurotransmitters (Shroff, 2016:1). Neurotransmitters act as the pathway of communication between the nerve cells in the brain (Shroff, 2016:01). If there is an imbalance in these chemicals, communication will be impaired, compromising the cognitive and conative abilities. Dryden-Edwards (2016:01) outlines that abnormal levels of neurotransmitters in the brain will cause negative reactions resulting in imbalances and psychiatric disorders. According to Bhandari (2016:1), influencing or altering the chemical neurotransmitters in the brain can improve brain function. An alteration in this instance may refer to medical/pharmaceutical management for a child suffering from a psychiatric disorder.

Studies reflect that children with ADHD and ODD often suffer from impairments in parts of the brain, such as the pre-frontal cortex, caudate and the cerebellum (Afolabi, 2016:1; Bhandari, 2016:1). Impairments to different neurons, cause impairments to emotions, thoughts, regulation of attention and negative actions (Afolabi, 2016:1). Due to these impairments, or an underdeveloped pre-frontal lobe, children with psychiatric disorders, such as ADHD and ODD, are increasingly susceptible to aggressive and risk-taking behaviour, and subsequently develop co-morbid disorders, such as CD (Afolabi, 2016:1; Vlok, 2016:1).

In addition to abnormalities in the brain, the experience of early childhood trauma is also causally linked to the propensity for crime (Anon, 2015:1). McAloon (2014:1) outlines that repeated experience of trauma in early childhood, such as parental neglect, abuse and/or malnutrition, will all have negative effects on the development of the brain. Children who have experienced complex trauma have impaired neural system abilities and impairments to the areas of the brain responsible for learning, rational thinking, and reasoning (McAloon, 2014:1). This impairment causes children, in everyday situations, to anticipate and behave in a manner as one would in trauma

or stressful situations (Anon, 2015:1; McAloon, 2014:1). Children who have experienced complex trauma may also exhibit characteristics similar to children with ADHD or CD, such as lack of concentration, poor judgement, aggressiveness and poor decision-making skills. Perry (2004:2) substantiates this argument by highlighting the negative impact that disrupted and traumatic development has on children. In this light, Perry (2004:2-3) outlines, "...a child with a brain adapted for an environment of chaos, unpredictability, threat, and distress is ill-suited to the modern classroom or playground". Amidst the challenges and consequential factors experienced, complex trauma is not a diagnosable disorder according to the DSM-5 (2013). Thus, treatment, for children suffering from trauma can be difficult as it would need to address the comorbid effects of stress and trauma.

It is significant that children residing in African countries, such as Namibia, Botswana, Nigeria and South Africa, are often exposed to compound trauma and are at higher risk of developing psychiatric disorders (Leoschut & Kafaar, 2017: 81-93; Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016: 168-169).

In addition to the direct impact of child maltreatment, pre-natal trauma has been found to affect brain development (Guizzetti, 2015:1). Guizzetti (2015:1) highlights that children exposed to prenatal alcohol also referred to as foetal alcohol syndrome, manifest physical, behavioural and learning difficulties. The prevalence of foetal alcohol syndrome in South Africa is one of the highest in the world, namely 29 to 290 per 1000 live births (Mkhize, 2016:1). VitalBrito (2018:1) posits that, due to poor socio-economic factors and deprived living conditions, South African children are at an increased risk of suffering from foetal alcohol exposure. Against this background, and for the purpose of this study, the focus will be drawn to the influence of foetal alcohol syndrome in relation to the development of cognitive or intellectual defects which influence behaviour.

Birth defects and primary disabilities experienced by children suffering from foetal alcohol syndrome include, but are not limited to, growth retardation, distinct facial appearance, brain abnormalities and neurodevelopmental disorders (Guizzetti, 2015:1). Children suffering from foetal alcohol syndrome may also experience learning disabilities, interpersonal relationship challenges, difficulty with reasoning

and decision-making, and developmental disabilities (Mkhize, 2016:1; VitalBrito, 2018:1). These factors increase the child's risk of school truancy, conflict with the law, development of mental illnesses and substance abuse (Mkhize, 2016:1; VitalBrito, 2018:1).

According to the South African College of Applied Psychology (2015:1), South African children are susceptible to develop psychiatric disorders, such as IDD, due to the prevalence of foetal alcohol syndrome. Mkhize (2016:1) concurs with the South African College of Applied Psychology (2015:1), as it is outlined that, "... a large portion of children with ADHD-like symptoms - a common behavioural disorder in all communities - could be attributed to alcohol consumption during pregnancy". This implies that, in addition to the children suffering from psychiatric disorders, children suffering from foetal alcohol syndrome and complex trauma are also at risk of coming into conflict with figures of authority, due to similar cognitive and conative challenges which cause them to react inappropriately or aggressively in social situations.

Biological causes are intricately linked to genetic or hereditary factors that influence the development of psychiatric disorder as discussed below.

2.2.2 Genetic/ hereditary factors

In addition to the influence of biological factors, mental disorders may be caused genetically or hereditarily (Freitas-Silva & Ortega, 2016:1). Individuals with a family history of mental illness are vulnerable to develop similar disorders, due to abnormalities in their genetic make-up. Research from the National Institute of Health (2013:1) outlines that common genetic psychiatric disorders include, but are not limited to, autism spectrum disorder,² ADHD, bipolar mood disorder and depression.

Studies from the American Academy of Paediatrics (2014:1) emphasise that the cause of psychiatric disorders is not only genetic but a combination of genetic and environmental factors. This is referred to as 'multifactorial inheritance' (American Academy of Paediatrics, 2014:1).

² Autism Spectrum Disorder [hereafter referred to as ASD].

Bhandari (2016:1) and the American Academy of Paediatrics (2014:1) outline that, although, genetically one may be born with the predisposition to develop a mental disorder; each person responds differently to their environment. The stimuli between environmental factors and genetic regulation will determine the development of the disorder (American Academy of Paediatrics, 2014:1). This process is referred to as 'epigenetic regulation' (American Academy of Paediatrics, 2014:1). Ergo, epigenetic regulation, namely the interaction between genetics and the environment, will differ with each person and will dictate if, and the extent to which that particular disorder will develop, and subsequently that child's susceptibility to criminal behaviour.

Afolabi (2016:1) highlights that although most psychiatric disorders have a genetic factor that shapes the developmental pathway, a holistic approach to identifying the trigger and aggravating factors of the disorder is vital for appropriate treatment. The identification of the cause, trigger and aggravating factors pertaining to the psychiatric disorder are especially significant in dealing with and treating child offenders with psychiatric disorders.

Considering this study, the argument pertaining to nature-versus-nurture; with respect to the cause of psychiatric disorders and criminal behaviour is of significance. Besemer, Ahmad, Hinshaw and Farrington (2017:161-178) conducted a study on the prevalence of criminal behaviour in children with criminal parents. Findings from this study outlined that children whose parents exhibited criminal behaviour had a higher risk of criminal behaviour themselves; in comparison to those whose parents did not have criminal behavioural tendencies (Besemer et al, 2017:161-178). Various bodies of research concur that children whose parents suffer from psychiatric disorders and exhibit criminal behaviour have an increased risk of developing similar psychiatric disorders and criminal behaviour (McCord, Widom & Crowell, 2001:70-71; Besemer et al, 2017:161-178). Findings from these studies confirm a positive correlation between genetics and a predisposition to criminal behaviour (Besemer et al, 2017:161-178; McCord et al, 2017:70-71). However, the influence of the environment must also be acknowledged as contributing to criminality.

2.2.3 Psychological factors

Psychological factors also influence mental health. The influence of psychological trauma, on a child's predisposition to develop a psychiatric disorder and become involved in criminal activity, is supported in research conducted by inter alia Perry (2004:2), McAloon (2014:1) and Geoffrey (2016:111-112).

Extreme psychological trauma, such as emotional, physical, or sexual abuse as a child, the loss of a parent or parental neglect, as well as poorly developed social abilities, may contribute to the development of a mental disorder (Shroff, 2016:01). According to Peltzer (1999: 646-650) and Van Der Merwe (2015:1), approximately 67 per cent of South African children experience some form of psychological trauma. Psychological risk factors that contribute to the development of a psychiatric disorder, include poor self-esteem, stress, and negative changes in relationships (Peterson, 2018:1).

Since the focus of this study pertains to children, an important psychological factor for adolescents, in addition to those mentioned above, includes hormonal changes, which will directly affect stress and mood (Dryden-Edwards, 2016:1). Fluctuating hormones, such as increased testosterone and cortisol, changes in the body and an increased ambivalence towards independence are some of the stressful factors experienced by adolescents, which increase anti-social behaviour (Rudo-Hutt, Gao, Glenn, Peskin, Yang & Raine, 2011:23; Dryden-Edwards, 2016:1). Children exposed to stressful environmental situations and who have a biological susceptibility to mental illness, are at an increased risk of developing psychiatric disorders, such as anxiety, CD or other disruptive, impulse-control, and conduct disorders (Dryden-Edwards, 2016:1). In addition, psychological trauma, such as stress during pregnancy, separation from the parent and abuse and neglect, may increase a child's susceptibility to psychiatric disorders and criminal behaviour (VitalBrito, 2018:1; Geoffrey, 2016:111-112).

According to Dryden-Edwards (2016:1), a combination of psychological, biological, and environmental factors causes psychiatric disorders. Environmental factors have a direct influence on psychological factors as discussed below.

2.2.4 Environmental factors

The primary cause for children with mental disorders to come into conflict with the law is that many of them come from underprivileged or socioeconomically challenged homes and/or, are exposed to increased levels of stress and trauma, and do not receive the needed care and treatment (Neumann, 2015:01). Environmental and psychological factors affecting children often overlap. Environmental factors which may contribute to, or trigger a psychiatric disorder, include trauma, child maltreatment, substance abuse, parental neglect, the death of a loved one and/or divorce (Bhandari, 2016:1). Although the influence of trauma, parental neglect, the death of a loved one and/or divorce, occur as environmental risk factors, the consequences overlap and can also be considered psychological factors. The influence of these environmental and psychological factors impacts the child's susceptibility to develop psychiatric disorders and also increase the risk of coming into conflict with the law.

According to research conducted on the prevalence of child mental health problems in Africa, Cortina et al (2012: 276-281) highlight that there is a clear correlation between mental health problems and children living in socio-economically challenged areas in Africa. Further support for the association, between socio-economic challenges and susceptibility to mental health disorders in children, was highlighted in research (Trollope, 2014:1; Ntsabo, 2018:1). These adverse conditions may influence a child's mental, physical, emotional, and social development and increase the risk of developing psycho-social problems (Cortina et al, 2012:276-281).

Trollope (2014:5) postulates that through the association of poverty and exposure to poor, negative environmental and psychosocial factors; mental illnesses develop. In addition to exposure to a poor socio-economic and psychosocial environment, the financial and social burden of caring for a child with a psychiatric disorder increases the risk of parents developing mental illnesses (Trollope, 2014:5).

The American Academy of Paediatrics (2014:1) concurs with Bhandari (2016:1) by highlighting that environmental factors, such as trauma (sexual, emotional or physical abuse and/or stressful home environments during childhood), emotional harm (exposure to bullying at school and/or at home) and substance abuse (both

prenatally and during childhood) have been associated with the development of psychiatric disorders.

Environmental stress can be caused by internal or external stimuli, which trigger a psychiatric disorder in a person, who has a biological, genetic, or psychological predisposition, or vulnerability to mental illness (Schroff, 2016:1). According to research, delinquency, and criminality associated with children who suffer from psychiatric disorder is not only a national but an international child justice dilemma (World Health Organisation, 2015:1; Pelser, 2008:4; Geoffrey, 2016:166-167). The influence of the environment becomes evident when children are exposed to similar negative environmental and societal factors, such as child-maltreatment due to poverty, exposure to trauma, neglect, and substance abuse due to socio-economic challenges, which increases both their risk of developing a psychiatric disorder and becoming involved in criminal activity (Neuman, 2015:1; World Health Organisation, 2015:1; Pelser, 2008:4). These environmental factors are similarly experienced in Namibia, Nigeria, Botswana, and South Africa. Thus, children residing in these countries are exposed to comparable socio-economic conditions and are therefore at an equal risk of coming into conflict with the law (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017:29-34; Paruk & Karim, 2016:548-550).

In terms of the socio-economic disparities, Ntsabo (2018:1) and Van Der Merwe (2015:1) indicate that in rural areas, governmental institutes do not provide routine counselling, screening, or detection to pick up psychiatric disorders in young people. These services are needed in rural areas in Africa, as research highlights the exposure to trauma, violence, and stress that children face (Van Der Merwe, 2015:1; Ntsabo, 2018:1). Although there have been community-based health services developed by the South African National Department of Health, the implementation and practice thereof are weak and minimal services are available to children suffering from psychiatric disorders in poorer areas in South Africa (Ntsabo, 2018:1; Van Der Merwe, 2015:1).

In addition to the environmental and socio-economic factors, cultural factors which influence behaviour, and subsequent criminal behaviour, are an important

consideration. These factors will be explored further in this study in relation to acculturation and its effect on child offenders with psychiatric disorders.³

Based on the literature explored in this section, it is averred that the causation of psychiatric disorders and criminal behaviour in children occurs on a multi-dimensional level. In the section to follow, theoretical underpinnings will be explored which will provide further support to the multi-dimensional, integrated approach required when dealing with child offenders with psychiatric disorders.

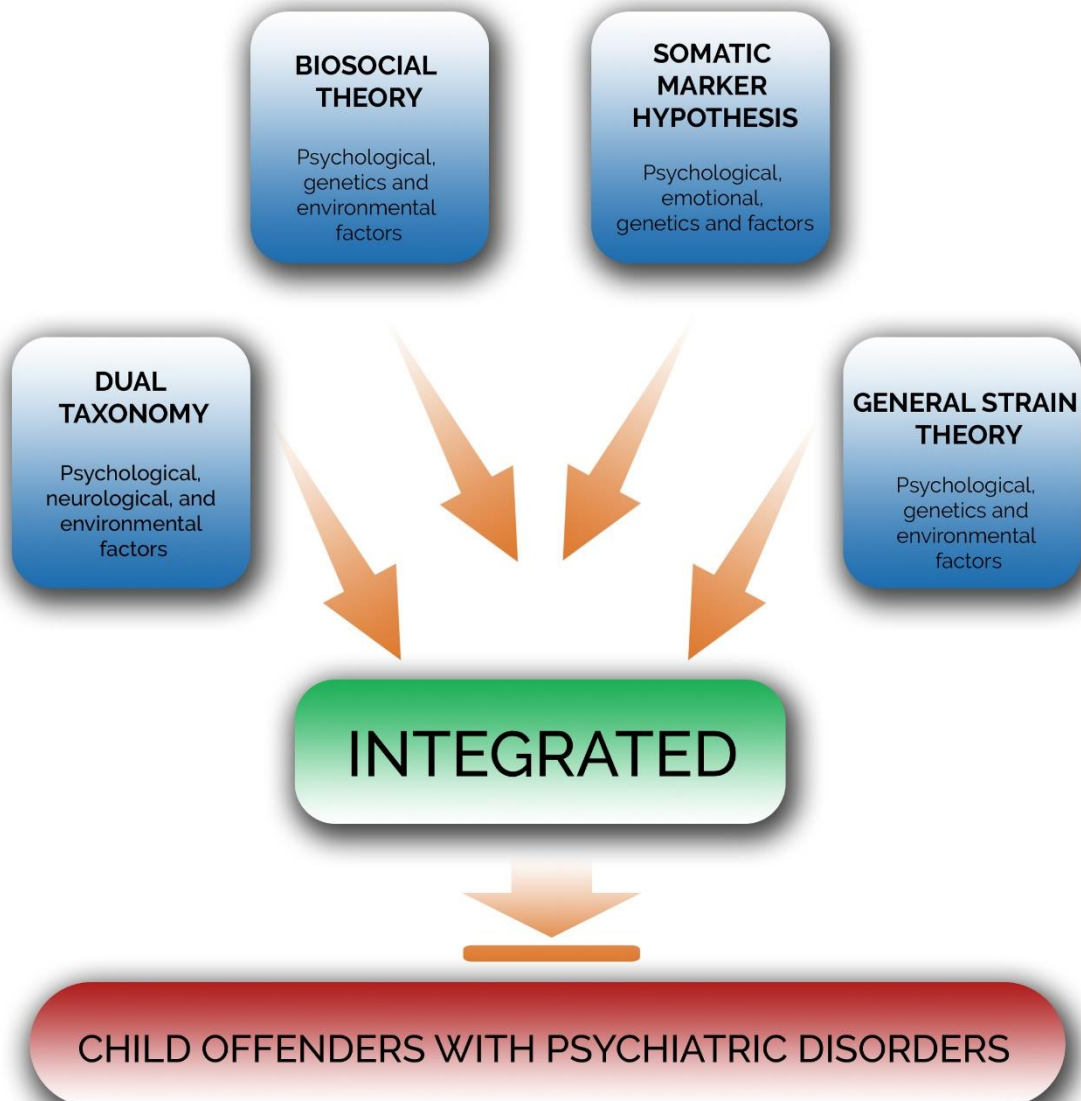
2.3 AN INTEGRATED THEORETICAL APPROACH TO EXPLORE THE CAUSAL LINK BETWEEN CRIMINAL BEHAVIOUR AND CHILDHOOD PSYCHIATRIC DISORDERS

An integrated theoretical approach involves connecting and synthesizing the principles of various theories and models to form a new, comprehensive approach to explaining the causes of crime and criminal behaviour (Barak, 2009:1). Through criminological theoretical association and synthesis employed in this chapter, the researcher reinforces that the cause and explanation of criminal behaviour cannot be answered from a single-dimensional approach. This implies that both criminal behaviour and psychiatric disorders cannot be explained from a purely genetic or psychological perspective. Neither can they be causative from a purely social or environmental perspective; as in the nature-versus-nurture argument.

Against the background of literature explored above regarding causative factors, and against the aim of this study, a holistic, integrated approach is best suited to this research. Integrated, multi-disciplinary theoretical underpinnings, such as the dual taxonomy, biosocial and general strain theory, used to explain causation of criminal behaviour and development of psychiatric disorders in child offenders is beneficial, since factors pertaining to the influence of both nature and nurture must be considered when dealing with this vulnerable group.

³ Refer to chapter 3, and chapter 5, regarding the influence of culture on a child's behaviour.

DIAGRAM 1: An integration of the theoretical frameworks applied to explain child offenders with psychiatric disorders



Integration and application of the aforementioned theories, which explore a spectrum of causes of crime, will provide support for and justify the aim of this study. The aim and objectives of this study are grounded in the principle that, in order to provide effective treatment to child offenders suffering from psychiatric disorders, a holistic, trans-disciplinary approach is required.

2.3.1 Dual Taxonomy Theory

The dual taxonomy theory is broad and aims to explain the age-crime-curve of anti-social and criminal behaviour in young offenders. Under this theory, Moffit (1993)

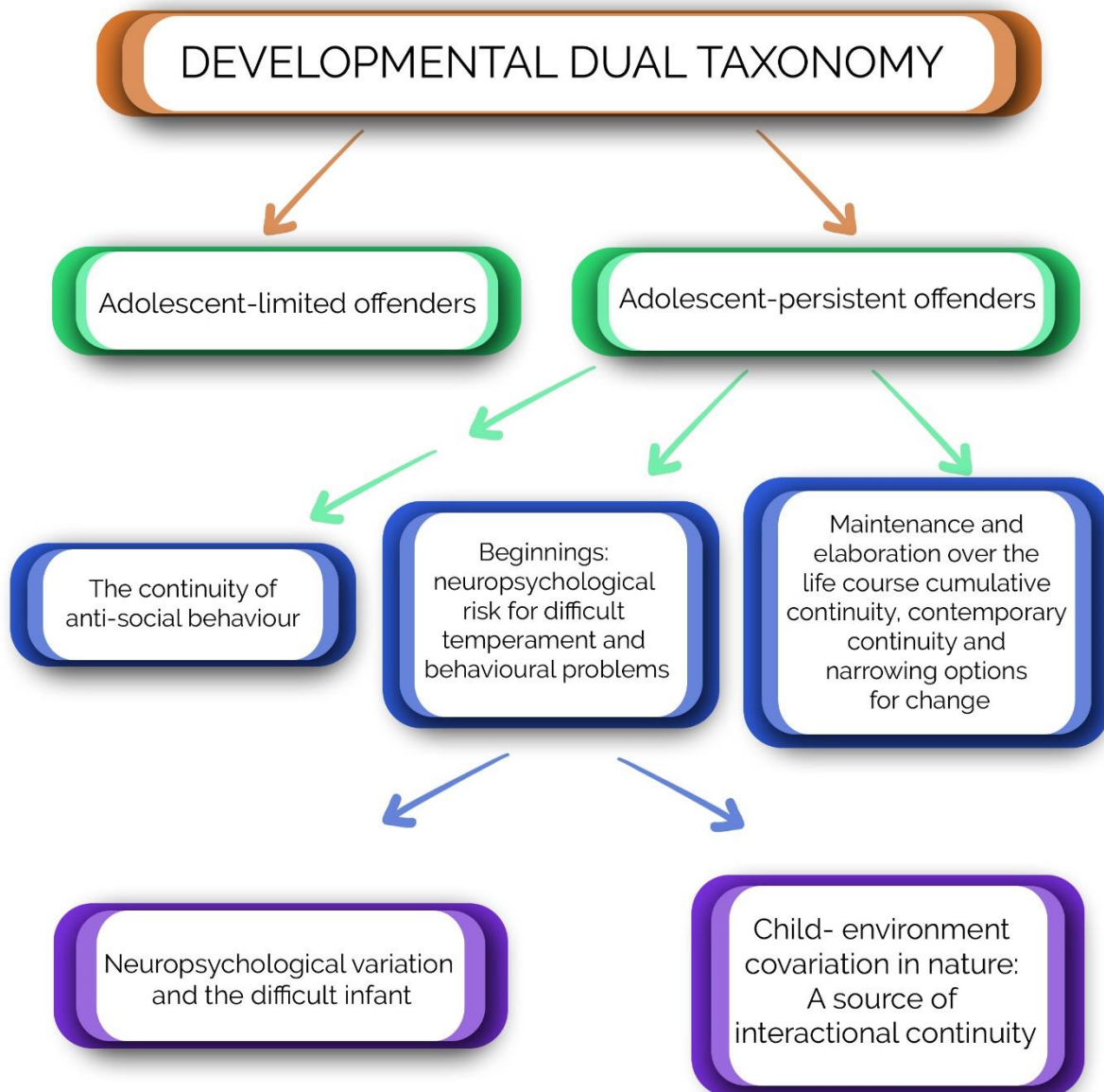
presumes two taxonomical types of anti-social, offending behaviour, namely life course persistent anti-social behaviour and limited adolescent anti-social behaviour. In addition to these types of anti-social and criminal behaviour, the dual taxonomy theory also posits the discontinuity of anti-social behaviour (Demuthova & Bucik, 2013; Ferreira, 2016:1).

Adolescent-limited anti-social behaviour specifically focuses on biological and social development during adolescence which influences anti-social and criminal behaviour (Demuthova & Bucik, 2013:18). Adolescent-limited offenders refer to the typical rebellious, teenager-like behaviour, namely, conflict with figures of authority, defying societal norms, abandoning family groups in favour of peers, testing one's abilities and boundaries and reactions to behavioural provocation (Siegel, 2016:321; Demuthova & Bucik, 2013:18). Criminal offences committed by this group are in general, minor, and non-violent offences (Demuthova & Bucik, 2013:18). Adolescent-limited offenders mimic defiant and rebellious behaviour and a reduction or discontinuation is noted in frequency by 18 years of age (Siegel, 2016:321).

Life-course persistent anti-social behaviour contrastingly explores the development of anti-social and criminal behaviour from childhood into adulthood (Ferreira, 2016:1). The causation of anti-social behaviour is explored and explained from a holistic stance, namely from pre-natal (biological/genetic causes) to post-natal (environmental and psychological causes), and the link this has to criminal behaviour (Siegel, 2016:321). Common features experienced by life-course persistent offenders include neurological deficits, family dysfunction, mental health problems, low academic achievements, and health issues (Ferreira, 2016:1).

Since the dual taxonomy theory explores criminal behaviour in life-course persistent offenders from a multi-factorial, holistic stance taking into consideration biological, neurological, psychological, and environmental factors, it is significant to this study. For this reason, the focus is drawn to life-course persistent offenders, and the correlation between this group of child offenders and children with psychiatric disorders who come into conflict with the law, in further detail below.

DIAGRAM 2: Theoretical underpinnings of the dual taxonomy theory to explain child offenders with psychiatric disorders



2.3.1.1 Adolescent-persistent offenders

As demonstrated in the diagram above, the dual taxonomy theory of anti-social behaviour includes three principle propositions under the life-course persistent offender: (1) *the continuity of anti-social behaviour defined* which explores and describes persistent anti-social behaviour (Moffit, 1993:679), (2) *beginnings: neuropsychological risk for difficult temperament and behavioural problems* which explores the interaction between neurological vulnerabilities and criminogenic environments; and (3) *maintenance and elaboration over the life course cumulative*

continuity, contemporary continuity and narrowing options for change which focuses on cumulative and contemporary influences for anti-social behaviour from adolescence into adulthood (Moffit, 1993: 679).

According to the dual taxonomy theory, life-course persistent offenders begin to manifest signs of anti-social behaviour in early childhood and as the child ages; the severity of their defiance and anti-social tendencies escalate (Boutwell, Barnes & Beaver, 2012:1). Life-course persistent offenders are estimated to account for 5 to 10 per cent of the general population and are responsible for more than 50 per cent of criminal offences (Boutwell et al, 2012:1).

Since the aim of this study is to explore, establish and substantiate the benefits of adopting a trans-disciplinary approach to dealing with child offenders with psychiatric disorders, the focus is drawn to *beginnings: neuropsychological risk for difficult temperament and behavioural problems*. This sub-proposition focuses on neurological and criminogenic factors influencing the child offender. This is done in an attempt to explain the causative factors of criminal behaviour and psychiatric disorders in child offenders, from a holistic perspective.

- **Beginnings: neuropsychological risk for difficult temperament and behavioural problems**

➤ ***Neuropsychological variation and the difficult infant***

Moffit (1993:681) proposes that life-course persistent offenders exhibit anti-social behaviour; typified by neuropsychological impairments; and the interaction between these impairments and the environment. Neuropsychological impairments refer to how the brain and nervous system influence daily functioning (Malik, 2017:1). Moffit (1993:681) viewed neuropsychology as the anatomical and physiological processes that influence psychological characteristics, such as behaviour, temperament, and cognition (Moffit, 1993:681).

Disruption or impairments in the neural development of an infant will negatively influence psychological development; which can be linked to anti-social behaviour in early childhood, adolescence, and young adulthood (Moffit, 1993:680-681; Siegel, 2016:321). Similarly, studies identify that impaired neural and psychological development influences the development of psychiatric disorders in children (Perry,

2004:2; Shroff, 2016:01). This theory proposes that the development of anti-social behaviour, and/or psychiatric disorders in early childhood are typified by irritability, impulsivity, and defiant behaviour. As the life-course persistent offender ages, the severity of poor self-control and defiance escalates, increasing the risk of rule-breaking and conflict with figures of authority (Demuthova & Bucik, 2013:18).

In addition to influencing the development of anti-social behaviour, neuropsychological impairments negatively affect the verbal and executive functioning of a child (Moffit, 1993:681). Verbal impairments include listening, reading, problem-solving, expressive speech, writing and memory disabilities; which are identifiable in childhood and adolescence. In the context of this theory, and of significance to this study, children suffering from milder forms of impaired executive functioning, also referred to as compartmental LD, include symptoms of inattention, impulsivity, impaired cognition, difficult temperaments, and anti-social behaviour (Demuthova & Bucik, 2013:18). These characteristics are similarly experienced by children suffering from ADHD, IDD and LD and are found to contribute to frustration and impulsivity (DSM-5, 2013: 33, 59, 60, 66-67, 462,470-473). Although this group of children experience difficulties, they are often able to function independently, with minimal assistance.

On the other hand, extreme impairments in executive functioning may manifest as autism or mental retardation and, children who suffer from extreme neurological deficits are easily identified and require support and assistance (Moffit, 1993:681). Due to the warning signs, should a child suffering from an extreme neurological deficit conflict with the law, the influence of the deficit will be identified, and the child will be dealt with in a manner which takes into consideration the influence of the deficit on the child's behaviour. In this light, the Child Justice Act (section 11 & 48) makes provision for children suffering from neurological deficits affecting their ability to fully appreciate the wrongfulness of a criminal act and to act in accordance with that understanding.

Due to the functioning capacity of children who experience less severe neurological deficits, or milder forms of impaired executive functioning, this group of children are not as easily identified (Demuthova & Bucik, 2013:18). The risk involved for the latter group of children is that, should they conflict with the law, the influence of

neurological deficits may go unnoticed, and the child will be dealt with in a manner which does not take into consideration the influence of his impairments.

In a similar instance, a reoccurring argument in this study highlights child offenders suffering from psychiatric disorders; and the lack of awareness or acknowledgement of the influence of the disorder on the child's behaviour in the justice system. As with the above-discussed group of children, child offenders suffering from psychiatric disorders may not always manifest extreme symptoms of the disorder, and the influence thereof may go unnoticed in the child justice system. In this case, the influence of the disorder on the child's behaviour and his criminal capacity, will not be taken into consideration and the child will be dealt with in an unjust manner (Geoffrey, 2016:81,87). In other words, the best interests of child offenders in this category of the disorder are not adequately protected by the current system.

Life-course persistent offenders suffering from neuropsychological impairments reflect similar, if not the same symptoms as children with ADHD and/or LD, and particular defiant characteristics of children with ODD and CD (DSM-5, 2013:59-60, 461; Moffit, 1993:681). This theory postulates that a distinct feature of a child displaying anti-social behaviour, similar to one who has a psychiatric disorder, is the inability to conform and to attain socially accepted, appropriate patterns of behaviour. The influence of neurological deficits, on the child's psychological, cognitive, mental, emotional, and social development, is of significance to this study since these are causal risk factors associated with both psychiatric disorders and criminal behaviour.

According to Moffit (1993: 680), factors pertaining to the development of a psychiatric disorder, anti-social behaviour and criminality are linked to the neuropsychological development of the brain. As discussed, environmental, as well as genetic, psychological, and social factors influence the development of the brain, which in turn influences the development of anti-social behaviour and psychiatric disorders. This substantiates the proposition that child offenders suffering from psychiatric disorders and/or neurological deficits must be dealt with using a holistic approach and in a manner, which meets the best interest of each child.

In the section to follow, covariation and how it influences neuropsychological impairments and the development of anti-social behaviour, psychiatric disorders, and criminal behaviour, is discussed

➤ ***Child- environment covariation in nature: a source of interactional continuity***

Findings from this theory postulate that neurological impairments influence the development of anti-social behaviour and psychiatric disorders for life-course persistent offenders (Moffit, 1993:680). A sub-category of life-course persistent offenders is the child-environment covariation which explores the interactional relationship between genetics and the environment, in relation to neurological deficits and anti-social behaviour for life-course-persistent offenders. Under this theoretical sub-category, Moffit (1993:680) acknowledges that, as genetics are responsible for shared facial features between children and parents; they are also responsible for shared structural and personality similarities in the neural functioning system (Kaiser & Raminsky, 2010:1; Demuthova & Bucik, 2013:18).

In the context of this theory, this implies that children of parents at risk of developing anti-social behaviour, are exposed to the same criminogenic factors in their environments which inadvertently increase their risk of anti-social and criminal behaviour. Children who manifest hyperactive, challenging behaviour; and who require firm discipline techniques, may have parents who portray similar behavioural characteristics and who lack consistent discipline techniques (Demuthova & Bucik, 2013:18). Children in need of special psychological care and remedial attention often have parents who are also in need of such care, or who have suffered similar deficits as children. Similarly, studies indicate that children who suffer from psychiatric disorders may also have parents who possess similar characteristics or genetic vulnerabilities, which make them susceptible to psychiatric disorders (Freitas-Silva & Ortega, 2016:1). Due to the genetic vulnerability, criminogenic factors in their environment may act as triggers which cause the emergence of the psychiatric disorder. Life-course persistent child offenders present neurological impairments and defiant behaviour and the task of raising such a child is difficult. The task becomes more challenging for a parent who also experiences similar difficulties.

In addition to the mentioned neurological and genetic influence, this theory postulates that environmental and biological factors, such as a lack of affection, poor parental care, pre- and post-maternal substance abuse, disrupted family environments, poor living conditions and child malnutrition, also trigger aggressive and defiant behaviour (Jeffrey, 1959:550; Moffit, 1993: 680). Life-course persistent anti-social offenders lack consistent parental guidance, corrective measures, and the ability to learn pro-social behaviour to reduce criminal tendencies. The result is that it negatively affects the child on a multi-dimensional level, causing feelings of rejection, anger, and hostility.

Moffit (1993:681) elaborated that although there is merit in the genetic factors predisposing a child to anti-social behaviour; children who are not born with neuropsychological impairments can still manifest anti-social behaviour as a result of environmental factors. This is also evident for children with psychiatric disorders. The dual taxonomy theory, therefore, enforces that in addition to genetic influences, environmental factors play an equal role.

Amidst the environmental influence, which is linked to criminal behaviour in children and life-course persistent offenders, Moffit (1993:681) makes a clear distinction that anti-social behaviour and criminal tendencies are not limited to the aforementioned environmental influences, namely exposure to poor living conditions and child malnutrition. This premise is repeatedly justified in the contents of this study, since it is reinforced that, in addition to the environmental factors which trigger criminal behaviour; biological and genetic factors must also be acknowledged. In other words, children residing in middle to higher income areas, who are biologically and genetically vulnerable to anti-social behaviour and/or psychiatric disorders, are equally at risk of developing psychiatric disorders and becoming involved in criminal behaviour, as children residing in poorer living conditions. The biological predisposition to anti-social behaviour and a lack of pro-social alternative behaviour allow the child to continue a cycle of negative behaviour which leads to criminal activity in the life course, i.e. life-course persistent offender (Moffit, 1993:683).

Amidst these factors, the dual taxonomy theory enforces the influence of environmental factors which play an equal, if not more key role in influencing anti-social and criminal behaviour and the development of psychiatric disorders in

children (Moffit, 1993:681). With that said, it must be reiterated that children living in underprivileged areas are more exposed to criminogenic risk factors, which evoke and exacerbate their anti-social behaviour. This premise is of significance to this study since the socio-economic strain experienced by children residing in African countries, not only increases their risk of criminal behaviour, but also pre-disposes them to psychiatric disorders.

Under the framework of this theory, Moffit (1993:682) explains that the continual process of reciprocal interaction between anti-social behaviour and negative environmental encounters creates a cycle of prolonged negative interactions. As a result of the variations in environment and aggressive behaviour, the child experiences neuropsychological impairments which are transformed into an anti-social style that permeates all spheres of adolescent and adult behaviour.

The theoretical foundation of the dual taxonomy theory highlights that the reciprocal relationship between genetic pre-disposition, criminogenic risk factors in the environment and a lack of resources to learn pro-social behaviour, are amongst the most significant contributors to anti-social and criminal behaviour, which is evident in life-course persistent offenders (Moffit, 1993:683). The theoretical foundation of the dual taxonomy theory can be applied to the context of this study in that genetic pre-disposition, criminogenic risk factors and a lack of resources to learn pro-social behaviour contribute to the development of psychiatric disorders and criminal behaviour in children who come into conflict with the law.

It can be concluded, that the mutualistic dependency found between internal and external stimuli; namely biological, genetic, and environmental factors; provide a clear indication that the causation of anti-social and criminal behaviour in children, cannot be explained from a single-dimension perspective focussing only on nature or nurture. Rather a multi-disciplinary approach, focused on both the influence of nature, as well as nurture to explain the development of psychiatric disorders and criminal behaviour, should be used. The association between biological, genetic, environmental, and social factors and a lack of opportunity to learn pro-social behaviour exacerbates anti-social temperament in various developmental domains, which diminishes the likelihood of learning socially acceptable behaviour.

Considering the theoretical foundation of the dual taxonomy theory, it is evident that adopting a single-dimensional approach to the causation of psychiatric disorders and criminal behaviour in child offenders is ineffective. Ergo, literature, as well as theory, supports the aim of this study, which is to recommend that a trans-disciplinary, holistic approach be adopted to effectively address, deal with and treat child offenders suffering from psychiatric disorders. By taking into consideration multi-factorial domains, which include environmental, psychological, social, genetic, and biological factors that cause and influence behaviour; the child will be dealt with in a manner which is case-specific, and treatment will be in the child's best interest.

The influences of genetic, environmental, and social factors on child offenders suffering from psychiatric disorders, is also substantiated in other criminological integrated theories, namely, the biosocial theory and general strain theory. In the section to follow, the biosocial theory will be explored to further establish factors contributing to the development of a psychiatric disorder and criminal behaviour in children who come into conflict with the law.

2.3.2 Biosocial theory

Similar to the principles of the dual taxonomy theory, the biosocial theory adopts a holistic, multi-factorial approach to explaining anti-social and criminal behaviour in both children and adults. The biosocial theory integrates and applies a broad spectrum of different criminological approaches from various behavioural sciences, namely evolutionary, biological, behavioural genetics, molecular genetics, and neurological approaches, to explain causation of anti-social and criminal behaviour (Piquero, 2016:76). For this study, the principles of the biosocial theory will be explored and guided by Fishbein (1990) and Piquero (2016) and applied in context.

The evolutionary approach focuses on the critical causes of crime (Piquero, 2016:76). The evolutionary approach aims to answer questions such as why anti-social and delinquent behaviour peak during adolescence. This approach offers explanations for why certain characteristics of criminal behaviour are universal, by analysing contemporary human behaviour and the origins of behaviour in a particular environment (Piquero, 2016:76).

The biological approach focuses on physiological factors related to anti-social and criminal behaviour (Piquero, 2016:78). This theoretical approach focuses on the influence of hormones, heart-rate and puberty onset/development in the aetiology of anti-social behaviour. The biological criminological approach is of significance to this study since it explores biological variations in crime causation, pre-disposition, and aggravating factors for child offenders suffering from psychiatric disorders.

The behavioural genetic approach examines the influence of genetics and the environment on human behaviour and personality (Piquero, 2016:78). This approach focused on the sibling relationship and twin-studies to differentiate between the effects of genetics versus the environment. Factors stemming from the behavioural genetic approach highlight genetic influences on a child's personality development, temperament, susceptibility to hereditary psychiatric disorders and anti-social behaviour. Since research (Besemer et al, 2017:161-178; Freitas-Silva & Ortega, 2016:1) substantiates the correlation between genetic influences on a child's predisposition to psychiatric disorders, and criminal behaviour, influential factors identified under the behavioural genetic approach are of importance and will be further explored in this study.

Molecular genetics focus on genomic science and its impact as a causative factor for anti-social behaviour (Piquero, 2016:80). Lastly, the neuro approach is the study of neurological mechanisms and their influence on criminal behaviour (Piquero, 2016:80). Neurological development influences the cognitive, psychological, emotional, social, and mental development of a child. As identified under the dual taxonomy theory, impairments in neurological development are found to increase a child's risk of developing psychiatric disorders, neurological deficits, and criminal behaviour (Moffit, 1993:681; Demuthova & Bucik, 2013:18). The neuro criminological approach is of significance to this study since it focuses on factors such as cognitive, psychological, emotional, social, and mental development, which is a multi-dimensional approach. Against the aim of this study, to adopt a holistic, trans-disciplinary approach to dealing with child offenders with psychiatric disorders, the principles of the neuro criminological approach will also be explored and applied in context.

As outlined under the framework for the biosocial theory; biological, genetic, and neurological approaches are adopted to explain risk factors contributing to criminal behaviour in children, which can be identified as early as birth (Kaiser & Raminsky, 2010:1). Since these approaches - biological, genetic, and neurological - incorporate multi-factorial perspectives in explaining the development of psychiatric disorders, anti-social and criminal behaviour in children, they are of significance to this study and will, therefore, be integrated and applied to the focus of this study.

DIAGRAM 3: Theoretical underpinnings of the biosocial theory

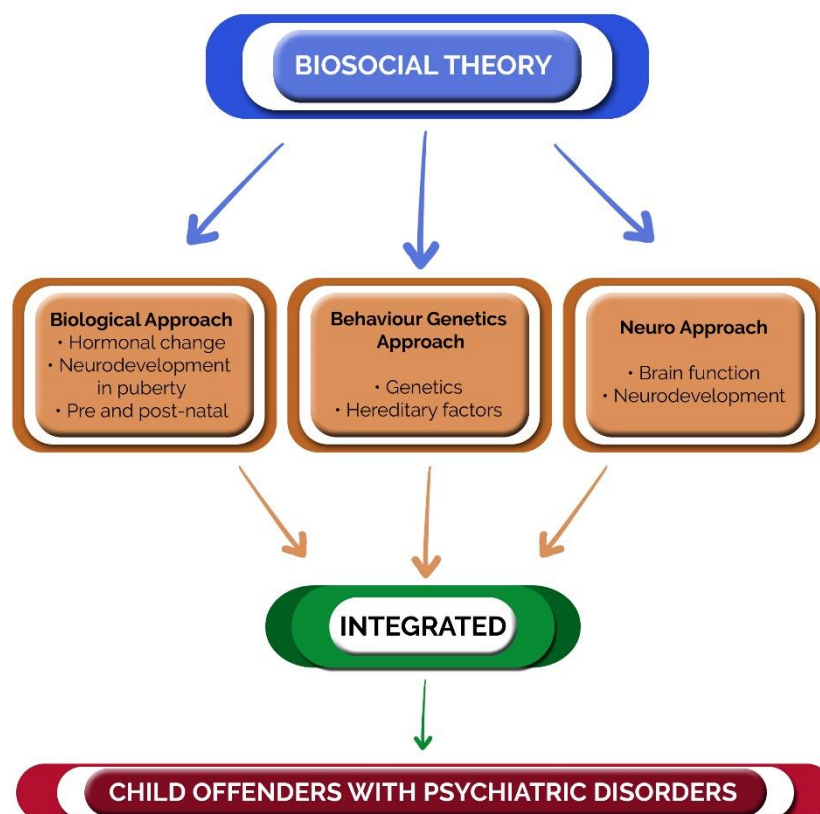


2.3.2.1 Biological, behavioural genetic and neuro criminological approach

The contents of this section will be explored as follows: under the biosocial theory, the biological sub-category will explore hormonal change and neurodevelopment in puberty, in response to anti-social behaviour. Under the behavioural genetic approach, the focus will be drawn to the influence of genetics and the nature-versus-nurture argument with respect to criminal behaviour in child offenders with psychiatric disorders. The neuro criminological approach highlights influential factors of brain functioning, neurodevelopment, and criminal behaviour.

Factors under biological, behavioural genetic and neuro criminological approaches will not be explored under the mentioned sub-categories of the biosocial theory but will be integrated and discussed holistically in order to create a context for the exploration of criminal behaviour in child offenders with psychiatric disorders. Lastly, the biosocial theory will conclude by documenting environmental and social factors which influence the development of psychiatric disorders and criminal behaviour in children in conflict with the law.

DIAGRAM 4: Theoretical underpinnings and sub-categories under the biosocial theory to explain child offenders with psychiatric disorders



- **Genetics**

The biosocial theory presumes that genetics is one of the factors that influence the development of anti-social and criminal behaviour (Siegel, 2010:143; Piquero, 2016:280). Under this theoretical framework, it is believed that genetic makeup is passed on from parents to children. Anti-social behaviour is therefore inherited, and genetic abnormality can cause a variety of anti-social behaviours (Siegel, 2010:143). According to research, approximately 40 to 60 per cent of criminal behaviour is hereditary (Rudo-Hutt et al, 2011:22).

Similar, to the dual taxonomy theory, the biosocial theory postulates that there is a genetic correlation between personality traits and temperament, and a genetic vulnerability to developing psychiatric disorders and criminal behaviour (Freitas-Silva & Ortega, 2016:1). Factors, such as impulsivity, depression, hyperactivity, defiance and intellectual deficits; which are symptoms of psychiatric disorders such as ADHD, ID, ODD and CD; are hereditary and must be taken into consideration since these are the precursors of maladaptive criminal behaviour (Fishbein, 1990:12-13; DSM-5, 2013:33, 59-60, 462-464, 470-473). The identification of these psychiatric disorders in children at risk of conflicting with the law is significant and these are the psychiatric disorders focused on in this study. According to literature, neurodevelopmental and disruptive, impulse-control, and conduct disorders, namely, ADHD, IDD, LDD, ODD and CD, are caused by various biological, genetic, neurological, psychological, and environmental influential factors (Anon, 2015:1; DSM-5, 2013; 31, 461; Parekh, 2018:1).

Literature presented in this chapter acknowledges the influence that hereditary and genetic factors have on one's predisposition to anti-social behaviour and psychiatric disorders. However, although there have been various bodies of research conducted on twin-and adoptive studies, pertaining to the inheritance of criminal behaviour, theorists under the biosocial theory opine that criminal behaviour is not always inherited (Fishbein, 1990:12-13). It is rather the way in which the individual chooses to react to the environment which creates the pre-disposition to criminal behaviour.

Kaiser and Rasminsky (2010:1) opine that, although personality traits, such as defiance and bad temperament can be considered hereditary, they can also manifest as environmental and criminogenic risk factors, due to parental neglect and child

abuse. Exposure to these risk factors can lead to the development of anti-social behaviour, psychiatric disorders, such as ODD or CD, and criminal behaviour. Due to the symptoms of defiance, impulsivity, and hyperactivity; children who are symptomatic, due to genetic vulnerability and who are exposed to environmental criminogenic risk factors, are at an increased risk of coming into conflict with figures of authority.

This opinion is substantiated by biosocial theorists and medical scholars who concur that, in addition to genetic and hereditary influence, it is the stimuli between the environment and one's genetic make-up, referred to as epigenetic regulation, which will determine the development of psychiatric disorders, anti-social and criminal behaviour (American Academy of Paediatrics, 2014:1; Bhandari, 2016:1; Fishbein, 1990:12-13). Kaiser and Rasminsky (2010:1,12-13) create a clear link to epigenetic regulation and state, "...some genes are expressed or turned on (or not) because of physical, social, and cultural factors in the environment; and some genes - for example those that influence difficult temperament, impulsivity, novelty seeking, and lack of empathy - pre-dispose people to be exposed to environmental risk". This statement lends further support to the premise of the biosocial theory which proffers that the development of psychiatric disorders, anti-social and criminal behaviour are influenced on a multi-factorial level.

The premise, on which the biosocial theory is grounded, is significant to this study since it highlights and reinforces that the causation of psychiatric disorders and criminal behaviour cannot be explained using a single-dimensional approach. A multi-dimensional approach, which integrates the influence of biology, genetics, and environment, to explain the phenomenon of child offenders with psychiatric disorders, is preferred. Intricately linked to genetics, is the influence of biological factors, namely pre- and post-natal factors that contribute to psychiatric disorders and criminal behaviour in children.

- **Pre- and post-natal factors**

In addition to the influence of genetics, the biosocial theory outlines biological birth factors, such as prenatal stressors and trauma, and neurodevelopment which impact the development of psychiatric disorders, anti-social and criminal behaviour in children (Siegel, 2010:132).

Under this theory, pre-natal stressors and trauma were identified as exposure to harmful substances, birth complications and child maltreatment. The biosocial theory places emphasis on foetal alcohol syndrome, as a specific risk factor linked to the causation of anti-social behaviour and criminality in children (Rudo-Hutt et al, 2011:19). For this purpose, and of significance to this study, it is important to draw attention to the influence of prenatal alcohol exposure, since children residing in Namibia, Nigeria, Botswana and South Africa, are more likely to be born into poor, negative environmental conditions and be exposed to prenatal alcohol consumption (Mkhize, 2016:1; VitalBrito, 2018:1).

The influence of foetal alcohol syndrome negatively affects the mental, cognitive, psychological, emotional, social, and physical development of a child and therefore pre-disposes the child to defective development during his life course (Guizzetti, 2015:1; Rudo-Hutt et al, 2011:17). Children suffering from foetal alcohol syndrome manifest similar impairments and deficits as a child with neurodevelopmental and disruptive, impulse-control, and conduct disorders, namely impaired cognitive abilities, impulsivity, inattentiveness, disruptiveness, and defiance (Guizzetti, 2015:1). Due to the behavioural consequences, these children are at an increased risk of coming into conflict with figures of authority where they lack the ability to fully understand the consequences of their actions, or practice self-control in order to conform to social norms.

The risk for a child with this vulnerability is that should the child who is in conflict with the law and is not visibly symptomatic, the child will be dealt with in a manner which does not take foetal alcohol syndrome into consideration as an influence on his behaviour. This is because there is no legislative provision which ensures that all child offenders who conflict with the law are assessed for the presence of a disorder or mental illness. Presently, the Child Justice Act (section 11 & 48) makes provision for the assessment of mental illness if it is identified and the child is symptomatic, and the disorder is found to influence the child's ability to appreciate the wrongfulness of actions and to act in accordance with that appreciation. The application of multi-factorial influential factors, for the development of psychiatric disorders and criminal behaviour in children, identified under the biosocial theory, is of significance to this study since it promotes the importance of adopting a multi-

disciplinary perspective to dealing with child offenders with psychiatric disorders. Since this study focuses specifically on children and adolescents, it is of importance to note that the biosocial theory places particular emphasis on the influence of hormonal changes on adolescents and the impact of impaired neurodevelopment.

- **Hormones and neurodevelopment**

Biosocial theorists postulate that interactions between biology, at a molecular level, and socially, at an environmental level, are linked to the causes of anti-social and criminal behaviour (Rudo-Hutt et al, 2011:20; Fishbein, 1990:16). In addition to the various other factors under the biosocial theory, such as genetics, birth, and the environment, it is important to take note of the influence of hormonal changes on the development of psychiatric disorders and defiant, aggressive, anti-social and criminal behaviour in adolescents.

According to Rudo-Hutt et al (2011:23), hormonal imbalances, such as increased testosterone and cortisol have been associated with anti-social behaviour. Testosterone is an androgen hormone produced by both males and females (Sherwood, 2017:1). During puberty (approximately 12 to 17 years of age), males are found to produce increased levels of testosterone (Sherwood, 2017:1). This hormone causes adolescent boys to develop 'man-like' characteristics, such as body hair, lowered voice tone, and increased physical growth (Sherwood, 2017:1). In addition to the physical attributes, testosterone also increases muscle development and structure, increasing strength and levels of aggression (Sherwood, 2017:1). According to Ellis (2014:1), studies show that increased levels of aggression are due to the effect that testosterone has on 'threat' processing by the human brain.

Duke, Balzwer and Steinbeck (2014: 315-322) conducted a study on the effects of testosterone on male adolescent mood and behaviour. Findings from this study reflected that although testosterone is known to increase aggressive and risk-taking behaviour in adolescent boys, factors such as negative environmental influence and a lack of parental supervision were identified as precursors to anti-social behaviour. This premise is supported under the biosocial theory, in that biosocial theorists postulate that it is a combination of internal stimuli, namely genetics, biology and hormones, as well as external stimuli, namely environmental factors, which

contribute to the development of anti-social behaviour and psychiatric disorders in children who come into conflict with figures of authority (Fishbein, 1990:12-13).

Since the biosocial theory draws the focus to adolescents; it is of significance to draw attention to the criminal capacity and legislative framework applicable to this group. According to the Child Justice Amendment Bill (2018:10), children between 12 and 14 years of age are rebuttably presumed criminally capable, unless proven otherwise. However, section 5 of the Act (Child Justice Act), fails to provide a protective mantle for children between 14 and 18 years of age who are presumed criminally capable unless they suffer from a mental illness. Children within this age group can be held liable for their actions unless a lack of *mens rea* can be proven. Here, an investigation into the child's cognitive, emotional, social, psychological, and moral development will be conducted (Child Justice Act, section 11). In light of the aforementioned literature under the biosocial theory pertaining to the effects of testosterone on aggression; children suffering from psychiatric disorders, within this age group are at particular risk in the child justice system since there is no specific system to assess, identify and determine the child's ability to appreciate his actions, to act in accordance with that appreciation and furthermore, to determine the influence of hormonal imbalances and/or psychiatric disorders on the child's criminal behaviour.

In addition to the influence of testosterone, biosocial theorists also highlight the effects of cortisol, and its relation to aggressive and criminal behaviour (Rudo-Hutt et al, 2011:23). Cortisol is a glucocorticoid hormone, which plays a vital role in the body's reactivity process; commonly referred to as 'fight-or-flight process', during times of stress (Blahd, 2016:1). According to Desjardins (2011:1), children who exhibit behavioural problems often have an imbalance or abnormally high or low levels of cortisol. Findings from this study (Desjardins, 2011:1) outlined that increased levels of cortisol have been linked to the cause and initiation of aggressive and anti-social behaviour whereas, life course persistent anti-social children, under the dual taxonomy theory, reflected low levels of cortisol. The reason for the imbalance, according to Desjardins (2011:1), is that although heightened levels of cortisol increase aggression, constant stress over a lengthened period causes cortisol levels to decline. This implies that the psychological response is numbed,

due to the extended period of exposure to stress in the environment. Research documented under the dual taxonomy theory and the biosocial theory supports the hypothesis that children with anti-social behaviour have low levels of cortisol and elevated levels of testosterone (Rudo-Hutt et al, 2011:23; Moffit, 1993:681).

With that said, both the dual taxonomy and biosocial theory, concur that due to the lack of emotional association, children with anti-social behaviour may be less responsive to social consequences and less fearful of danger, such as the potential punishment from coming into conflict with the law (Fishbein, 1990:12-13; Rudo-Hutt et al, 2011:23; Moffit, 1993:681). Thus, this group of children are at an increased risk of coming into conflict with the law, due to the lack of association between high-risk situations and negative consequences.

The danger associated with not identifying hormonal imbalances and impaired emotional development and/or emotional immaturity in this group of children is twofold. Firstly, the child will be dealt with in an unjust manner which fails to take into consideration the influence of the hormonal imbalance and emotional immaturity, as highlighted above. Secondly, in providing treatment to children suffering from hormonal imbalances and/or psychiatric disorders; the child will be unresponsive to conventional, single-dimensional child justice treatment, which only focuses on behavioural correction or intervention. In this respect, a more individualised, holistic, and case-specific approach to treatment will better address the needs and best interest of each child.

In addition to the effect of hormonal imbalance, the biosocial theory also focuses on the influence of neurodevelopment in relation to anti-social behaviour and delinquency. Research substantiates that cognitive development and intelligence are directly linked to susceptibility to criminal behaviour (Sleek, 2015:1). It is also linked to and at the core of the development of psychiatric disorders. This premise is supported by findings from Rudo-Hutt et al (2011:31,32), which outline the association between decreased levels of intelligence, poor executive functioning, and anti-social and criminal behaviour.

The executive function is responsible for regulating the cognitive process and is controlled by the pre-frontal cortex (Rudo-Hutt et al, 2011:32). According to Sukyirun

(2016:101), executive functioning is responsible for three areas, found in the pre-frontal cortex; namely, inhibitory control (which is the ability to control behaviour), working memory and cognitive flexibility (which is the ability to adapt and adjust to one's needs in a situation).

Due to abnormalities, or the under development of the pre-frontal cortex, children with neurodevelopmental and disruptive, impulse-control, and conduct disorders reflect poor executive functioning and anti-social behaviour and are therefore at risk of coming into conflict with figures of authority (Rudo-Hutt et al, 2011:32). Both the biosocial theory and the dual taxonomy theory support that parental anti-social behaviour and pre-and post-natal alcohol abuse is linked to poor executive functioning and anti-social behavioural traits in children (Rudo-Hutt et al, 2011:33; Moffit, 1993:681; Fishbein, 1990:12).

In addition to impairments in the pre-frontal cortex, biosocial and dual taxonomy theorists concur that poor environmental factors, such as disruptive familial structures and exposure to violence can cause anti-social behaviour in children (Rudo-Hutt et al, 2011:33; Moffit, 1993:681; Fishbein, 1990:12). Environmental factors contributing to the development of psychiatric disorders and criminal behaviour in children are discussed below.

- **Environmental factors**

Factors so far discussed focus on the 'nurture' aspect of psychiatric disorders, anti-social and criminal behaviour in children (Neumann, 2015:1; Bhandari, 2016:1). These included genetics, hereditary and biological influence. Amidst these factors, the influence of 'nature', namely social and environmental influences, were also discussed, which in conjunction with the 'nurture' factors, were found to contribute to the development of psychiatric disorders and anti-social, criminal behaviour in children.

Paragraph 2.2.4 above highlighted the impact of socio-economic strain, an environmental factor, facing many child offenders in African countries, which is an important influential criminogenic variable under the biosocial theory. Biosocial theorists postulate that exposure to child malnutrition, parental neglect, disruptive neighbourhoods and criminogenic environments, which are compounded by other

sub-optimal social and environmental conditions, pre-dispose a child to delinquency, more than the influence of biological and psychosocial issues (Fishbein, 1990; Rudo-Hutt et al, 2011:20; Demuthova & Bucik, 2013:19; Neumann, 2015:1).

Pertaining to environmental criminogenic risk factors, Gottfredson and Hirschi's (1990), social control theory, asserts that children reared in a stable, supervised, loving environment are less likely to become involved in criminal activity, in comparison to children reared in an unstable, abusive, unsupervised environment. Here, the lack of social control is found to perpetuate the development of anti-social and criminal behaviour in children.

Zirpoli (2014:1) avers, that in addition to the risk of developing anti-social and criminal behaviour; poor social conditions also affect academic performance, social behaviour, and the overall wellbeing of a child. With these damaging factors in mind, children residing in poor socio-economic conditions, such as many in Namibia, Botswana, Nigeria and South Africa, are constantly exposed to criminogenic risk factors, to wit a lack of adequate parental supervision and/or positive role models, disruptive living environments, and are unable to receive necessary care and intervention (Zirpoli, 2014:1). As outlined earlier, the influence of hormonal imbalances under the biosocial theory; individuals exposed to constant stress and negative emotional experiences are at risk of manifesting inappropriate, anti-social behaviour due to a misinterpretation of the situation and lack of fear of social consequences (Eklund, 2006:39).

A combination of an anti-social, hostile attitude, impulsivity and poor self-control results in aggression which brings these children into conflict with figures of authority. Impulsivity, poor self-control, and defiance are commonly found in child offenders who suffer from ADHD, ODD, CD and ID (DSM-5, 2013:33, 59-60, 462-464, 470-473). The influence of poor socio-economic conditions and child malnutrition, in conjunction with psychiatric disorders, create constant strain which perpetuates a cycle of defiant, criminal behaviour.

As mentioned, the impacts of socio-economic strain are of particular significance to the biosocial theory and to this study since many children residing in the

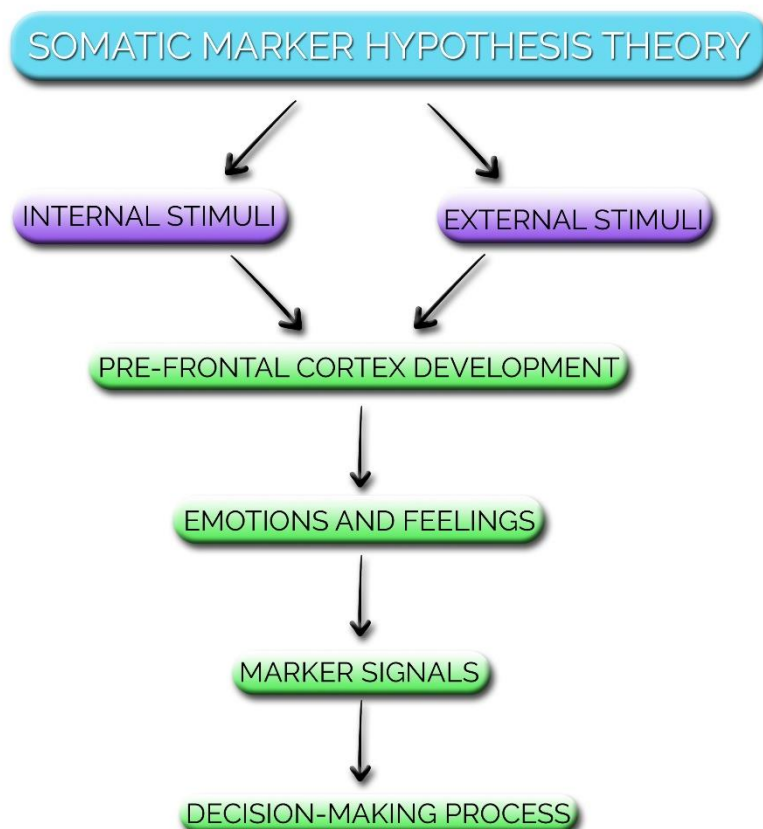
aforementioned African countries, are exposed to these conditions and are at an increased risk of psychiatric disorder and potential criminality.

The somatic marker hypothesis theory, which explores the impact of brain development, in relation to decision-making, to wit cognitive and conative processing, will be discussed below. This theory is of significance, with respect to cognitive and conative functioning and the criminal capacity of child offenders with psychiatric disorders.

2.3.3 Somatic marker hypothesis

Damasio and Bechara's (2005), somatic marker hypothesis theory provides an alternate approach to explain the thought process and rationality of child offenders. This theory emphasises the association between brain development, emotional response, and cognitive and conative function. Here, the decision-making process is explained through a bio-regulatory process which occurs when the nervous system elicits responses of somatic states as reactions to certain negative or positive environmental stimuli (Damasio & Bechara, 2005:337). In other words, during the bio-regulatory process, emotions, and feelings, which are influenced by internal and environmental stimuli, send marker signals which affect decision-making.

DIAGRAM 5: Theoretical underpinnings of the somatic marker hypothesis theory to explain child offenders with psychiatric disorders



The theoretical foundation of the somatic marker hypothesis theory is grounded on the premise that healthy development of the pre-frontal cortex is vital to ensure healthy cognitive, psychological, mental, social, and moral development (Damasio & Bechara, 2005). One of the functions of the pre-frontal cortex, with the support of other areas of the brain, is that it is responsible for creating associations between situations and physiological responses (Buchanan, Driscoll, Mowrer, Thayer, Kirschbaum & Tranel, 2011:1). According to Damasio and Bechara (2005:337), the emotions also referred to as the somatic markers, associated with a particular action, is a crucial factor to consider. The identification of these emotions or feelings is an innate mechanism which leads the child to avoid punishment/pain and achieve pleasure/reward from the anti-social act, by identifying and linking past action to consequence. In this light, somatic markers are therefore an essential key to preventing further anti-social behaviour and providing effective treatment to child offenders with psychiatric disorders (Damasio & Bechara, 2005:1).

However, this theory further postulates that an underdeveloped or impaired pre-frontal cortex, often found in children suffering from psychiatric disorders, negatively influences emotional development and therefore the decision-making process. Underdevelopment or impaired pre-frontal cortex development manifests in poor emotional and behavioural control, defiance, and impulsivity and could lead to the development of neurodevelopmental and disruptive, impulse-control, and conduct disorders (Moffitt, 1993; Agnew, 2001:319; Fishbein, 1990; Damasio & Bechara, 2005; DSM-5, 2013: 33, 59,60,66-67, 462,470-473).

The somatic marker hypothesis theory highlights that the decision-making process is not purely a process of rationality but also a process of emotional responses linked to a particular situation (Damasio & Bechara, 2005:337-338). Emotional, psychological, cognitive, and conative development is of significance to this study, since these are factors taken into consideration when determining the criminal capacity for children in conflict with the law (Child Justice Act, section 11).

According to this theory, although children with psychiatric disorders may have the intellect or rational ability; due to impairments caused by the psychiatric disorder, they fail to fully activate somatic states associated with reward and punishment and therefore make uninformed, impulsive decisions. This implies that impairments in the pre-frontal cortex weaken the overall development and therefore place the child at a disadvantage in terms of cognitive and conative functioning; which in turn increases the risk of conflicting with authority figures. The ability to rationalise and logically process the foreseeable consequences of a criminal act, and refrain from high-risk behaviour, as determined in section 11 of the Child Justice Act, may not always be possible for this group of children. Sections 76 to 79 of the Criminal Procedure Act provide legislative stipulation, pertaining to the influence of psychiatric disorders on the child's ability to understand legal proceedings and the influence of the psychiatric disorder on criminal capacity. If it is found that, due to the influence of the psychiatric disorder, the child is unable to understand the consequences of his actions and to act in accordance with that understanding, the child shall not be held criminally liable for the misconduct (Criminal Procedure Act, section 78).

However, in respect to the somatic marker hypothesis theory, although this group of children possess intellect and rationality, their basic cognitive and conative functions

are impaired. Thus, children who experience impaired somatic functioning may not have the characteristics, required for protection under section 78 of the Criminal Procedure Act. Against this background, this group of children demonstrate the ability for rational choice and cognitive processing but lack the conative functioning, and the emotional development to associate actions with consequences. The question then arises, how does the child justice system correctly assess and determine their criminal capacity and justifiably deal with this group of children?

This premise, under which the somatic marker hypothesis theory is grounded, is also supported under the dual taxonomy and biosocial theory, specifically pertaining to impairments in the pre-frontal cortex and the development of psychiatric disorders and criminal behaviour in children (Moffit, 1993; Agnew, 2001; Fishbein, 1990).

It is evident from the theoretical analysis above, that there are numerous factors that ought to be considered when dealing with child offenders with psychiatric disorders. The somatic marker, dual taxonomy and biosocial theory all acknowledge the influence of nature as well as nurture in the development of psychiatric disorders, anti-social and criminal behaviour in children. All three criminological theories function on the premise that various environmental, genetic, biological, and psychological factors affect and/or impair the development of the brain. It is with this in mind that attention is drawn back to children residing in the comparative countries selected for this study, many of whom are exposed to poor environmental factors which place them at risk of impairments to the pre-frontal cortex and therefore psychiatric disorders which may predispose them to childhood criminality.

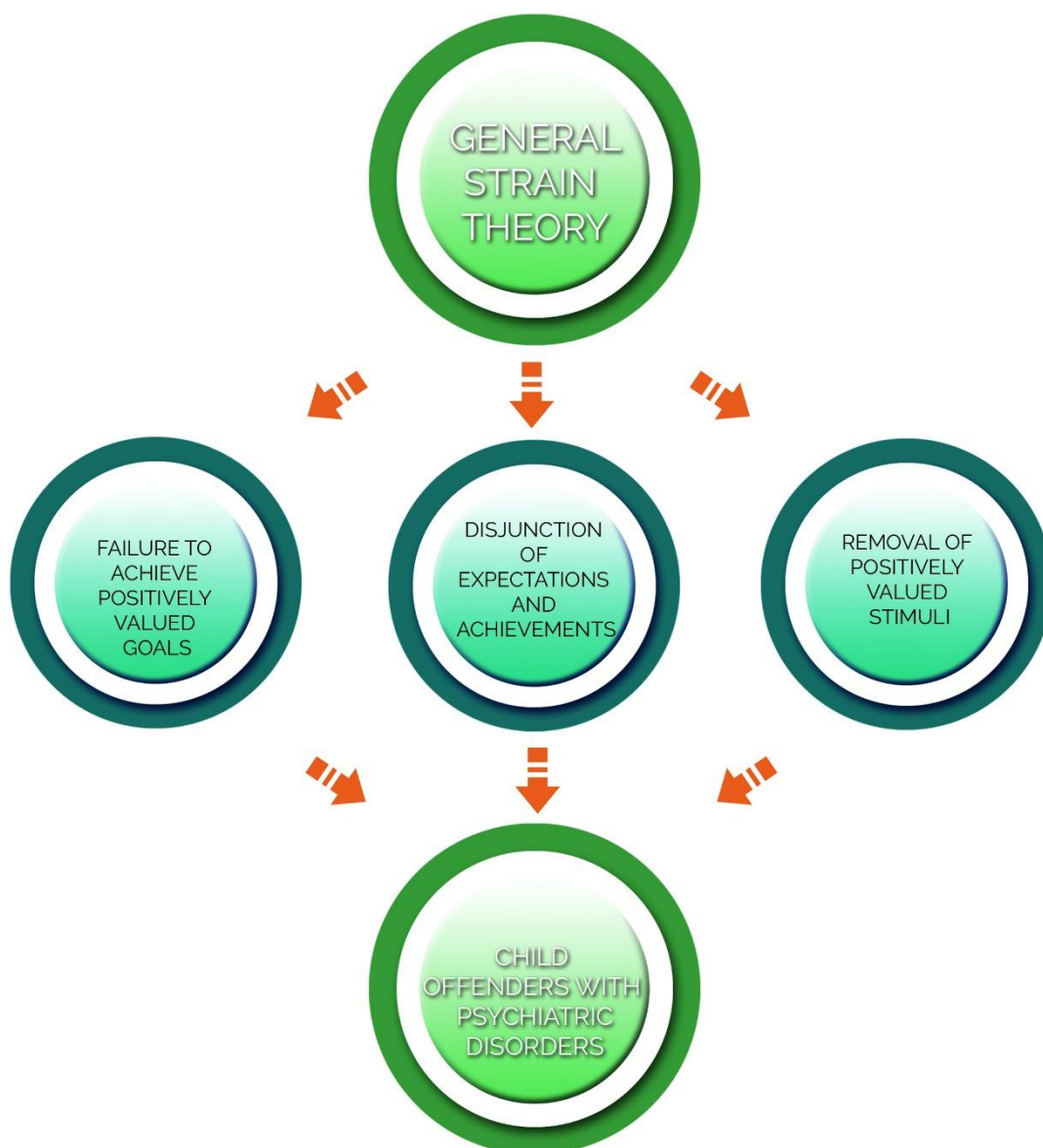
These criminological theories provide additional support to the aim of this study, which is to impress the importance of dealing holistically with child offenders with psychiatric disorders, from a trans-disciplinary approach. Like the principles of the dual taxonomy and biosocial theory and aspects of the somatic marker hypothesis theory, the general strain theory is premised on the influence of nature and nurture to explain criminal behaviour in children in conflict with the law.

2.3.4 General strain theory

The general strain theory, fathered by Robert Agnew, functions on the premise that stressors, referred to as strain, trigger negative emotional responses, anti-social and

criminal behaviour (Agnew, 2001:319). Like the dual taxonomy and biosocial theory, the general strain theory focuses on the association between environmental causes (nurture), which affect emotions, psychological and cognitive functioning (nature) and therefore influence criminal behaviour. This theory postulates three major types of strain, namely, *failure to achieve positively valued goals*, *disjunction of expectations and achievements* and *removal of positively valued stimuli* (Siegel, 2010:194). These major strain types are explored below in relation to children.

DIAGRAM 6: Theoretical underpinnings of the general strain theory to explain child offenders with psychiatric disorders



Failure to achieve positively valued goals refers to a child/adolescent who is unable to achieve goals through valid channels and reacts in anger/aggression (Burns, 2013:61; Rupper, 2014: 14). *Disjunction of expectations and achievements* refers to the strain experienced through the influence of negative stimuli; such as disrupted family, poor living environment, socio-economic difficulties, child malnutrition and/or bullying at school (Burns, 2013:61; Rupper, 2014: 14; Agnew, 2001:230). Children experiencing this type of strain become increasingly aggressive, defiant, and involved in risk-taking behaviour (Burns, 2013:61; Agnew, 2001:230). If corrective action is taken to remove or reduce the influence of the negative stimuli and is replaced by positive stimuli, the child will be able to reinterpret the stressful situation and respond to corrective measures effectively. However, if there are no measures taken to curb the aggressive and anti-social behaviour, the child/adolescent will continue a pathway of delinquency and ultimately criminal behaviour.

Removal of positively valued stimuli refers to a loss of positive stimuli in the environment. This includes the loss of a parent/sibling or separation from positive peer association, which results in anti-social and defiant behaviour (Burns, 2013:61; Rupper, 2014:14). Without the positive stimuli in the child/adolescent's life; the experience of strain can cause anger which, without proper corrective action, will result in restfulness, aggression, and anti-social and delinquent behaviour (Burns, 2013:61).

The application of this theory in the context of this study is of importance since strain can be interpreted as exposure to trauma, child malnutrition, socio-economic difficulties, poor living environments, lack of parental care and supervision, exposure to violence, physical and/or sexual abuse, bullying at school and disrupted family environments, which are criminogenic risk factors experienced by many children residing in the jurisdictions of comparison in this study (Bhandari, 2016:1; Royal College of Psychiatrists, 2014:1; Piquero, 2016:227).

According to Agnew (2001:319), criminal behaviour manifests in an attempt to reduce pressure in order to meet a particular action. In addition to the influence of environmental strain, Rupper (2014:5) proposes that a person's response and adaptation to strain, using conventional emotional, behavioural, and cognitive coping strategies, will determine susceptibility to criminal behaviour.

Reaction to stressors is a crucial factor under the general strain theory. In the context of this study, children suffering from neurodevelopmental and disruptive, impulse-control, and conduct disorders; manifest impulsive, defiant behaviour, with impaired cognition, difficult temperaments, limited social skills and anti-social behaviour (DSM-5, 2013: 33, 59,60,66-67, 462,470-473; Demuthova & Bucik, 2013:18). The functional consequences associated with the previously mentioned characteristics worsen the pressure of strain and are therefore also causative to delinquency and criminal behaviour (Rupper, 2014:17-18). Coping or corrective measures used to combat strain include anti-social behaviour due to disrupted family environments, stealing to overcome poor living conditions and socio-economic strain, defiance, and aggression due to exposure to violence and the use of illegal substances to alleviate negative emotions (Piquero, 2016:227). Children experiencing strain are most likely to react as a coping mechanism. Without the influence of positive support, the child is rendered unable to choose alternate coping methods.

The influence of the psychiatric disorders, in conjunction with the impact of environmental factors, offer insight into the risk and inclination experienced by this vulnerable group of children towards criminality. Findings from the dual taxonomy, biosocial and somatic marker hypothesis theory concur that a child's reaction to internal and external stimuli will predict the development of criminal behaviour. It must be acknowledged that children residing in African countries are found to be at an increased risk of aggravating the symptoms of the psychiatric disorders and developing anti-social and criminal behaviour, due to exposure to negative environmental stimuli, such as inter alia, poor socio-economic conditions, exposure to violence, child malnutrition and disrupted family systems (Bhandari, 2016:1; Royal College of Psychiatrists, 2014:1). If this group of children do not receive assistance to reduce or remove the negative stimuli, they may find themselves in a cycle of continued anti-social and criminal behaviour; and eventual conflict with the law.

Further to the influence of negative environmental stimuli which cause the anti-social behaviour, these children do not receive appropriate, individualised, effective care, within the child justice system, that addresses causative and aggravating factors. This is due to a lack of specialised professionals, and the present single-dimensional

approach used to deal with child offenders with psychiatric disorders. A lack of positive stimuli and inappropriate care lowers the ability for self-efficacy, and/or strengthened conventional coping mechanisms, which can potentially reduce anti-social and criminal behaviour in children.

The general strain theory proposes that increased exposure to strain triggers negative emotional responses, which worsen the risk for delinquency (Rupper, 2014:2). Thus, it is established that due to the influence of high levels of negative emotions, poor self-efficacy, poor self-control, environmental and psychological strain, these children are more likely to respond with 'corrective' action against the strain and cope in a defiant manner which brings them into conflict with the law (Rupper, 2014:1). Additionally, if the influence of the psychiatric disorder is not identified in the child justice system; factors causing the delinquent behaviour will not be acknowledged and addressed, causing more strain on the child, thereby exacerbating his frustration and aggression, stemming from the psychiatric disorder.

The above creates a cyclic response to delinquency and criminal activity. To reduce strain, or in light of this study, to reduce children with psychiatric disorders from coming into conflict with the law, negative environmental stimuli must be reduced and the child's ability for self-efficacy developed. It is argued that reducing negative stimuli, specifically in the child justice system, should include using a multi-disciplinary approach whereby each child's needs are case specific and the factors influencing the anti-social/criminal behaviour are addressed from a holistic approach.

2.4 AN INTEGRATED APPROACH TO PSYCHIATRIC DISORDERS AND CRIMINALITY

The dual taxonomy, biosocial, somatic marker hypothesis and general strain theories highlight the interacting role of nature and nurture in the development of psychiatric disorders, anti-social and criminal behaviour of children (Moffit, 1993; Demuthova & Bucik, 2013; Agnew, 2001; Rupper, 2014; Fishbein, 1990; Rudo-Hutt et al, 2011). The dual taxonomy, biosocial theory, and general strain theory outline the psychological, environmental, social, cognitive, and emotional influence on the child's development and the impact this has on the development of criminal behaviour. According to findings from the aforesaid theories, children exposed to

socio-economic strain, child malnutrition, violence, poor living conditions, peer pressure and disrupted familial structures, are at risk of developing anti-social, defiant behaviour which could bring them into conflict with authority figures (Moffit, 1993; Demuthova & Bucik, 2013; Agnew, 2001; Rupper, 2014; Fishbein, 1990; Rudo-Hutt et al, 2011).

The somatic marker theory focuses on brain development and the cognitive and emotional impairments experienced by children suffering from an underdeveloped pre-frontal cortex, which contributes to the development of psychiatric disorders and criminal behaviour (Damasio & Bechara, 2005:337). Children suffering from psychiatric disorders experience impulsivity, poor logical thinking and processing of information, poor emotional, behavioural, and cognitive self-control and experience an impaired ability for higher executive functioning. In addition to brain development, the somatic marker hypothesis theory highlights the influence of environmental factors which affect brain development. This theory functions on the premise that an underdeveloped pre-frontal cortex will cause impairments in the development of the child's executive, cognitive and conative functioning and will, therefore, affect psychological, emotional, and social development (Damasio & Bechara, 2005:337). According to Damasio and Bechara (2005:337), impaired development will affect the child's ability to associate an action to a consequence, and furthermore weaken the ability to practice behavioural and emotional self-control.

The somatic marker and general strain theory place further emphasis on emotional responses, triggered by environmental factors which dictate the child's behaviour (Damasio & Bechara, 2005:337; Agnew, 2001). The ability to rationalise and logically process the foreseeable consequences of a criminal act, as determined in section 11 of the Child Justice Act, may not always be possible. In addition to the influence of the psychiatric disorders, the decision-making process is therefore not purely a process of rationality but also a process of cognition and emotion linked to a particular situation (Damasio & Bechara, 2005:337-338).

Against the background of these theories, exposure to the aforementioned stressors in the environment, in conjunction with the influence of psychiatric disorders and impaired psychological, emotional and social development, not only pre-dispose the child to coming into conflict with the law, but also exacerbate the child's risk of

continuing on a path of criminal behaviour. Furthermore, these impairments are found to weaken a child's ability to distinguish between right and wrong and to act in accordance with that understanding. Thus, the influence of these factors not only increases the child's risk of criminal behaviour but also affect criminal capacity.

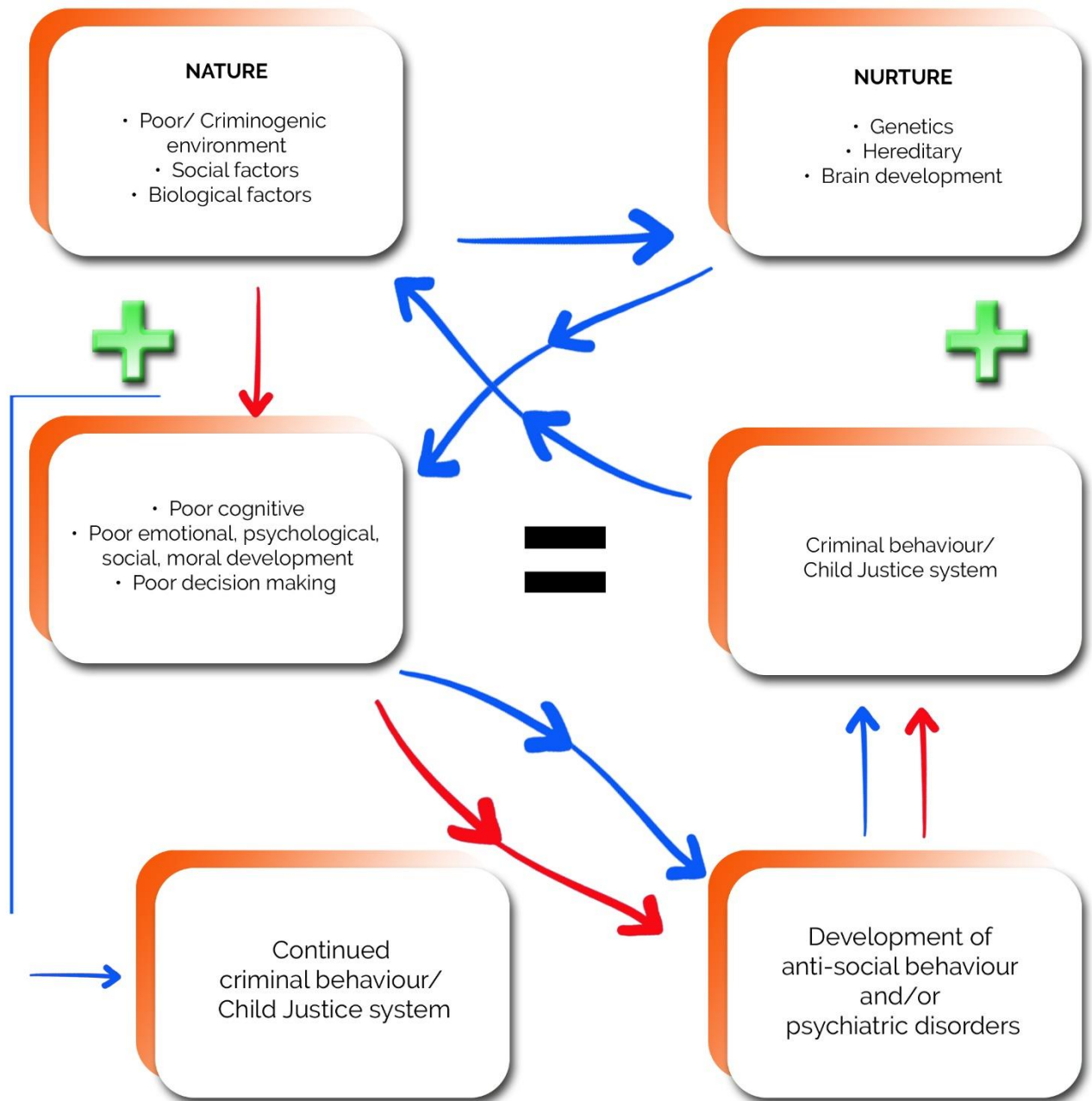
Against the background of the dual taxonomy, biosocial and the somatic marker theory; in addition to the environmental influences, even though individuals may have normal intellectual abilities, impairments in the pre-frontal cortex, which cause a failure in the somatic process, may provide a clear explanation for the initiation and continuation of anti-social behaviour (Damasio & Bechara, 2005:338). Fishbein (1990:7) highlights a key factor which must be acknowledged; a child who portrays anti-social behaviour, psychiatric symptoms and/or criminal behaviour does not equal a child with low intelligence. A child with a psychiatric disorder, or one who portrays anti-social or defiant behaviour, does not mean he will become involved in criminal activity. It is a combination and relation of the various aspects in tandem that cause criminal behaviour.

The literature discussed earlier in this study substantiates the underlying genetic and environmental influence on a child's susceptibility to psychiatric disorders, impaired psychological, emotional, social, and cognitive development, and the risk of criminal behaviour. The integrated theoretical approach taken in this chapter provides further justification for the risks for children exposed to environmental and psychological strain. According to the theories discussed, personalised rehabilitation becomes a challenge, as parents or figures of authority, do not recognise the cause and seriousness of the behavioural issues in early childhood and subsequently fail to provide appropriate care and reinforcement. Demuthova and Bucik (2013:19) are of the opinion that the absence of appropriate correction or intervention, causes further developmental impairments and allows for further behavioural issues, with an increase in severity during late adolescence and early adulthood. Thus, according to the dual taxonomy and the biosocial theory; criminal behaviour is secondary to an underlying primary behavioural issue (Moffit, 1993; Fishbein, 1990). To curb criminal behaviour, the primary issues must be addressed, treated, and monitored, from a holistic and individualised perspective.

The focus of this chapter is to provide a theoretical foundation to substantiate that the causation of psychiatric disorders and criminal behaviour in children is multi-factorial. For a child, who enters into the justice system, to be dealt with effectively, it is essential that an integrated, multi-dimensional approach is taken whereby a team of trans-disciplinary professionals address the various influential factors causing and aggravating anti-social and criminal behaviour.

The diagram below provides a summary of the above discussed integrated theories to explain criminal behaviour in child offenders with psychiatric disorders.

DIAGRAM 7: Theoretical integrated model explaining the link between criminal behaviour and psychiatric disorders



The theoretical integrated model above explains the cause and continuation of child offending from a holistic approach. Here, the primary factors from the dual taxonomy, biosocial, somatic marker hypothesis and general strain theory were collated to explain anti-social and criminal behaviour in children. According to this model, there

are two integrated processes explaining the development of psychiatric disorders, criminal behaviour, and anti-social behaviour in children.

Integrated process 1 (blue arrow): Aspects found in one's genetic make-up (nurture) are influenced by aspects found in the environment (nature) which leads to the development of poor cognitive, emotional, psychological, social, and moral development and poor decision-making. The impact of impaired development will lead to psychiatric disorders and anti-social behaviour. The manifestation of anti-social behaviour and psychiatric disorder leads to and pre-disposes the child to criminal behaviour. If the strain in the environment, which caused the anti-social behaviour and psychiatric disorder, persists, the child will continue on a cyclic path of anti-social and criminal behaviour.

Integrated process 2 (red arrow): According to the biosocial and the dual taxonomy theory, criminogenic risk factors found in the environment, can also lead to the development of psychiatric disorders and anti-social behaviour. A child who suffers from anti-social behaviour/psychiatric disorders, and who experiences continued negative encounters in the environment, will suffer from poor emotional, cognitive development, and decision-making skills which will bring him into conflict with the law (Rudo-Hutt et al, 2011:33; Fishbein, 1990; Moffit, 1993).

2.5 CONCLUSION

This chapter highlighted the importance of adopting a comprehensive approach, whereby adequate attention is granted to the influence of nature and nurture when dealing with child offenders with psychiatric disorders. Although a child with a genetic predisposition or weakness to psychiatric disorders and/or criminal behaviour may be susceptible to criminality, the influence of negative environmental factors is what triggers the anti-social behaviour. Thus, using only genetics or biological factors (nature) to assess risk factors and dictate the treatment is insufficient, resulting in a preference for medical intervention rather than holistic intervention for child offenders with psychiatric disorders, which takes into consideration the effects of poor environmental factors (nurture). Discrimination against any of these aspects could result in vital influential factors slipping through the cracks, rendering the child the injustice of not being treated and dealt with appropriately by the child justice system.

As mentioned, child offenders suffering from psychiatric disorders are presently dealt with using a single-dimensional approach, in the child justice system. This approach does not meet the best interest standard since factors influencing the child are multi-factorial in nature.

In the chapter to follow the influence of psychiatric disorders on problem-behaviour will be explored. Here, a detailed discussion will be presented on the classification, categorisation, and diagnostic criteria for neurodevelopmental and disruptive, impulse-control, and conduct disorders in children. This chapter concludes with an exploration of the prevalence of psychiatric disorders, suffered by child offenders in the jurisdictions under comparison, and the influence thereof on children in the child justice system.

CHAPTER 3

DEALING WITH CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS

3.1 INTRODUCTION

Childhood psychiatric disorders are found to have a multi-dimensional impact which affects the child, family, and community (Murphey et al, 2013:46). Severe anti-social and defiant behaviours often precede the development of delinquent tendencies in children (Sevecke, Kosson, & Krischer, 2009:01). Children who suffer from psychiatric disorders, such as ADHD, ODD and CD, manifest impulsive, defiant, and disruptive behaviour (DSM-5, 2013:59, 60, 426, 470-473). The influence of these psychiatric disorders is found to impair psychological and intellectual functioning and may, therefore, cause weakened impulse control, the inability to regulate social behaviour and to interpret social situations (Austin et al, 2014:513-514). As a result of the weakened impulse control, and poor ability to regulate social behaviour, children with psychiatric disorders are inclined to engage in high-risk, defiant activities which often bring them into conflict with authority figures (Grisso, 2008:146).

Mental-illness has influenced child behaviour and contributed to increased delinquency for many years. In the 1980s there was a dearth of research which explored the prevalence of mental illness in children in conflict with the law and the necessary treatment thereof (Penner, Roesch & Viljoen, 2011:1). As a result, children suffering from psychiatric disorders, who came into conflict with the law, were dealt with under the same legislation as adult offenders suffering from psychiatric disorders. Scientific bodies exploring this phenomenon have since expanded and there are vast volumes of substantial research conducted on children with mental illness in conflict with the law, some of which will be presented in this chapter (Penner et al, 2011:215).

The correlation between psychiatric disorder and delinquency has been substantiated by various bodies of research (Coker et al, 2014:888-898; Grisso,

2008:148; Murphey et al, 2013:4; Swanepoel, 2015:3238). Geoffrey (2016:167, 168) identified ADHD, LD, IDD, ODD and CD as prevalent psychiatric disorders found in South African child offenders. Furthermore, the symptoms associated with these psychiatric disorders were identified as risk factors for the causation of criminal behaviour.

In addition to the aforementioned disorders, ASD was also identified in literature as a disorder that increases the risk of criminal activity, and victimisation and influences the criminal capacity of children who come into conflict with the law (Bishop, 2008:3; Strickland, 2011:7-8; DeAngelis, 2011:1; Frekelton, 2011:251-252 ; Austin et al, 2014:537-538). Contrastingly, Geoffrey's (2016:129-131) research found that although children suffering from ASD are prone to victimisation, due to their impaired ability to understand social cues, limited risk of criminal activity was identified in this group.

Amidst the development that has occurred in research pertaining to the influence that psychiatric disorders have on pre-disposing children to criminal behaviour, it is important to note that South African child justice legislation, which will be discussed in chapter 4, still deals with child offenders with psychiatric disorders under the Criminal Procedure Act - which is legislation intended for adults. Presently, there is no child justice provision or regulation specifically dedicated to children with psychiatric disorders, who conflict with the law.

With that said, children with psychiatric disorders, who find themselves in conflict with the law, have an increased vulnerability due to the impact of the psychiatric disorder. Ergo, holistically assessing the emotional, psychological, moral, social, and cognitive aspects is of dire importance, in order to ensure that the special needs of these children are addressed in the child justice system.

The aim and focus of this chapter are to explore the process used to deal with child offenders with psychiatric disorders. Here, the concept of psychiatric disorders and their influence on criminal behaviour will be discussed. The classification, categorisation, characteristics, and symptoms of prevalent psychiatric disorders, as identified will be explored. The purpose is to acknowledge and draw attention to the influence that psychiatric disorders have on behaviour and their impact on pre-

disposing children to criminal activity. The incidence of psychiatric disorders found in child offenders (in Africa and South Africa) will be outlined. This chapter concludes with a discussion of the influence psychiatric disorders have on a child within the child justice system.

It is of significance to reiterate, that this chapter explores the influence of psychiatric disorders on child offenders from a criminological perspective and not a medical, psychological, or psychiatric perspective. The aim of this study is to propose legislative and practical amendments for an improved, trans-disciplinary framework that can be used to deal with child offenders with psychiatric disorders, from a multi-disciplinary, holistic perspective. It is in cognisance of this aim that this chapter does not go into detail regarding diagnostic procedures but rather provides an overview of contextual information pertaining to the classification, categorisation, symptoms and characteristics of ADHD, IDD, LD, ODD and CD. Opinions expressed in this chapter, pertaining to psychiatric disorders, are therefore supported by literature and previous research conducted by the researcher.

3.2 BRIEF HISTORY OF THE DEVELOPMENT OF THE DSM-5 (2013) AND THE ICD-10 (2015) AS INTERNATIONAL CLASSIFICATION AND DIAGNOSTIC MANUALS

The ICD-10 (2015) is an international diagnostic tool, which provides a diagnostic system for classifying all general epidemiological health-related problems (World Health Organisation, 2018:1). The first inclusion of mental disorders was incorporated in 1952 in the ICD-6, to provide a better clinical explanation for outpatient abnormal behavioural manifestations, and to collect statistical information about mental health (American Psychiatric Association, 2018:1). This brief inclusion supported 10 categories of psychoses and psychoneuroses and seven categories for disorders of character, intelligence, and behaviour. Broader and more detailed classification systems have since been developed. The ICD-6 and ICD-7 inspired several changes resulting in a more detailed diagnostic system of definitions for mental disorders. According to the American Psychiatric Association (2018:1), because of the limited knowledge of mental disorders, the World Health Organisation

sponsored a comprehensive review of the diagnostic issue. This gave rise to the first DSM in 1952, which included modifications from the ICD-6.

Changes in and development of the ICD-10 (2015), and the DSM-5 (2013), required lengthy and comprehensive research from a range of professionals to establish a firm empirical basis. As has been the case over the years, the development of the ICD influenced the development of the DSM, and presently, the ICD-10 (2015), reviewed and published in 2015, has a separate mental and behavioural disorders section (American Psychiatric Association, 2018:1). The DSM-5 (2013), which was under a lengthy research process for 13 years, was published in 2013 (American Psychiatric Association, 2018:1). Both the ICD-10 (2015) and the DSM-5 (2013) are American based and developed manuals but are recognised and used internationally.

It must be acknowledged that after review, the DSM-5 (2013) provides a more detailed description of the diagnostic features, associated features, characteristics, functional consequences, development and course, risk and prognostic factors, culture related diagnostic issues, gender-related diagnostic issues, differential diagnosis and comorbidities of each psychiatric disorder, when compared to the ICD-10 (2015). Based on the particular focus of the DSM-5 (2013), which specialises in diagnosis for mental health disorders, in comparison to the ICD-10 (2015), which is a diagnostic tool for all epidemiological health-related issues, the DSM-5 (2013) will be the primary manual referred to in this study.

According to the American psychiatric association (2018:1), the DSM-5 (2013) and the ICD-10 (2015):

“...should be thought of as companion publications. DSM–5 contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the code numbers used in DSM–5 and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies”.

Based on the wealth of information pertaining to mental disorders in the DSM-5 (2013), in comparison to the ICD-10 (2015), conclusions and diagnosis drawn from the ICD-10 (2015), may not take into consideration various factors, such as the specifiers and contributing factors, which are documented in the DSM-5 (2013). For example, the ICD-10 (2015) does not make mention of the specifiers, which a medical practitioner must consider when diagnosing CD, which is documented in the DSM-5 (2013:470-471).

It is important that child justice practitioners, who deal with children suffering from psychiatric disorders, are knowledgeable and mindful about the differences in the diagnostic criteria childhood psychiatric disorders. Specific to this study, this is of significance in that child offenders who manifest with psychiatric symptoms are identified in the child justice system and are addressed and dealt with in terms of methods of practice and treatment thereof.

As mentioned, this study adopts a criminological perspective. It is not the aim of this study to draw a comparative analysis between the function of the ICD-10 (2015) and the DSM-5 (2013) but to rather advocate for the adoption of a trans-disciplinary approach to dealing with child offenders suffering from a psychiatric disorder(s). The researcher takes cognisance of the diagnostic discrepancies in the ICD-10 (2015) and DSM-5 (2013) as two international diagnostic manuals and will identify this in the recommendations as an area for further research.

3.3 THE CONCEPT MENTAL ILLNESS/PSYCHIATRIC DISORDER AND EFFECT ON CRIMINAL BEHAVIOUR

As discussed earlier, a mental or psychiatric disorder may be defined as a clinically significant behavioural impairment of cognitive and emotional regulation (DSM-5, 2013: 20). This impairment manifests as a dysfunction in the psychological, biological, and/or developmental process of mental function (DSM-5, 2013: 20). The influence of a psychiatric disorder affects one's emotional state, thinking and social abilities to relate to others and subsequently impairs the ability to cope with the demands of daily life (Swanepoel, 2015:3239). Against this background, it can be acknowledged that the influence of a psychiatric disorder may influence one's

predisposition towards criminal behaviour and further impact one's ability to appreciate the wrongfulness of actions and ability to control such actions.

According to Swanepoel (2015:3240), the concept of mental or psychiatric disorder differs in various professions:

- In a clinical context:

“... a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (for example a painful symptom) or disability (for example impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (for example, political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual...” (Stein et al 2010:1762-1763).

- In a legal context:

“... a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such diagnosis” (Mental Health Care Act, section 1).

As mentioned, the DSM-5 (2013) is an international diagnostic manual used by clinical practitioners to diagnose patients suffering from psychiatric disorders. The DSM-5 (2013:59) makes clear the diagnostic purpose of its diagnostic schedule:

“... DSM-5 is also used as reference for the courts and attorneys in assessing the forensic consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in the DSM-5 (2013) was developed to meet the needs of clinicians, public

health professionals, and research investigators rather than all of the technical needs of the court and legal professionals”.

The clinical concept of mental/psychiatric disorder provides a clear description in order for a clinical practitioner to make a diagnosis; whereas the legal concept of a mental /psychiatric disorder depends on the determination by the mental health practitioner in order to make a diagnosis. Although the primary source used by mental health practitioners, namely the DSM-5 (2013), provides a clear and detailed outline of the symptoms, time-frame and behavioural characteristics to identify and diagnose a psychiatric disorder, many children suffering from psychiatric disorders, such as CD and ODD, are at risk of being misdiagnosed or not being diagnosed at all. The reason for this, according to Boezaart and Skelton (2011:18), is that many mental health practitioners do not recognise certain disruptive, impulse-control, and conduct disorders, such as CD and ODD, as mental disorders but rather as a behavioural issue that requires behavioural modification and alternate methods of therapy.

Point in case is the opinion from a medical practitioner that “ODD is just a description...it’s simply a description of the child’s responses to the environment” and “CD is also just a description, it’s not something that’s wrong with the child, it’s something that the child is doing” as expressed in research (Geoffrey, 2016:134-135). This opinion implies that one would need to address the behavioural issues only, rather than holistically assess the child from a medical perspective, thereby addressing hormonal imbalance or biological cause, as well as social and environmental factors influencing behaviour. Contradictory opinions were noted in Geoffrey’s (2016:135) research than that expressed by the medical practitioner, in that the symptoms and behavioural manifestation from the disorder increase the child’s risk of delinquency, rather than the disorder itself. To deliver effective and individualised services to child offenders suffering from psychiatric disorders, such as CD and ODD, a holistic treatment approach is needed, rather than only behavioural intervention, which is a single-dimension approach.

Another point of contention is that the British Psychological Society and the Royal College of Psychiatrists (2013:1) concur with the opinion that the cause of ODD and CD may lay with environmental influence and stimuli, such as school teachers,

friends, parents, and siblings, rather than a lack of medical management. Although there may be merit in this explanation, children suffering from psychiatric disorders, such as ODD and CD, require more than just social intervention in order to reduce recidivism and prevent anti-social, delinquent behaviour.

Such opinions are concerning since ODD and CD are diagnosable psychiatric disorders under the DSM-5 (2013:426, 470). The challenge regarding the discrepancy found between medical practitioners and their opinion of these psychiatric disorders lies in the definition of a psychiatric disorder in the South African Mental Health Care Act (section 1). As mentioned, although medical practitioners use the DSM-5 (2013) as a diagnostic manual, the definition stipulated in the Mental Health Care Act (section 1) fails to create standardisation by providing a clear outline for all practitioners, defining a mental health disorder, but rather allows each medical practitioner to interpret and define mental health disorders on their own accord.

The contrasting opinion by the British Psychological Society and the Royal College of Psychiatrists (2013:1) however included an admission that “...in addition to social causes there are substantial genetic and biological contributions to conduct disorders/anti-social behaviour; therefore, the contribution of these factors needs to be assessed and factored into intervention plans”. Children with psychiatric disorders, such as ODD and CD, suffer from physical detriments linked to brain development, neurotransmission and chemical imbalances. If child justice practitioners, both medical and legal, do not recognise and do not identify the necessity of holistic services to these children, the risk and implication are that children who suffer from psychiatric disorders, and who require medical management, will not receive the needed care. Additionally, co-existing disorders, which often need medical intervention, will go undiagnosed and untreated. The risk exists that children suffering from psychiatric disorders may, therefore, continue a spiral of delinquent behaviour without any means of help or rehabilitation.

The importance of assessing all child offenders who enter into the child justice system, for the presence and manifestation of psychiatric disorders is acknowledged. However, to provide effective treatment to this group of children and for the child to be receptive to the treatment, it is important to conduct a holistic assessment. With

that said, this study proposes that a trans-disciplinary approach will adequately identify all possible factors that influence the child; including emotional, psychological, environmental and social causes, for children suffering from psychiatric disorders and co-existing conditions.

Against the background of child justice legislation, which will be discussed in chapter 4, the concept of psychiatric disorder and its influence on criminal activity ultimately highlights the influence of the disorder on the child's cognitive and conative ability. Cognitive function refers to the ability to reason, perceive and process information (McLeod, 2015:1). According to Allen and Kelly (2015:1), cognitive abilities in children refer to learning competencies and the ability for self-regulation (which has a cognitive and emotional dimension). The conative function refers to one's behaviour and the ability to practice self-control; it is a direct reflection of the cognitive abilities (Dennis, Simic, Bigler, Abildskov, Agostino, Taylor, Rubin, Vannatta, Gergardt, Stancin & Yeates, 2013:25-39). In other words, cognitive abilities regulate intellectual abilities, executive functioning, and the ability to think and process information. Conative abilities refer to one's actions because of the intellectual abilities, executive functioning, and processing of information.

The influence that psychiatric disorders have on the cognitive and conative functioning of a child, in relation to the increased risk of delinquent behaviour is of importance to the study. This is because it highlights the significance of not only identifying the influence of the psychiatric disorder, and its comorbidities, but also the significance of providing comprehensive services and treatment to the child in order that his special needs, and the factors pre-disposing him to psychiatric disorders and criminal behaviour, are addressed. To provide such services, it is vital to make a clear distinction of the categorisation, symptoms and characteristics associated with each disorder. In the section below, these factors will be discussed, according to the DSM-5 (2013).

3.4 PSYCHIATRIC DISORDER CATEGORISATION, SYMPTOMS AND CHARACTERISTICS ACCORDING TO THE DSM-5 (2013)

Children who are symptomatic of psychiatric disorders experience a change in behaviour, such as bedwetting, poor school performance, boredom, complaints of

headaches and stomach aches, changes in sleep and appetite, aggressive or withdrawn behaviour and increased risk-taking behaviours (Dryden-Edwards, 2016:1). Symptoms are dependent on the type and severity of disorder and age of the child.

As mentioned, research conducted in South Africa identified ADHD, LD, IDD, ODD and CD as the most common psychiatric disorders found to influence children in conflict with the law (Geoffrey, 2016:121). It is of significance to outline that psychiatric disorders focused on in this study, are categorised under neurodevelopmental and disruptive, impulse-control, and conduct disorders, according to the DSM-5 (2013:31, 461). A clear distinction between the psychiatric disorder categories will be made below.

3.4.1 Category of psychiatric disorders

The categorisation under which a psychiatric disorder is classified is dependent on the manifestation, symptoms, and characteristics of the disorder (Salters-Pedneault, 2018:1). There are various categories of psychiatric disorder, which include neurodevelopmental, depressive, anxiety, obsessive-compulsive and related, trauma-and stress-related, disruptive, impulse-control, and conduct, and substance-related and addictive psychiatric disorders (Salters-Pedneault, 2018:1). ADHD, LD and IDD are categorised under neurodevelopmental disorders and ODD and CD under disruptive, impulse-control, and conduct disorders (DSM-5, 2013:31, 461). Ergo, for the purpose of this study, the focus will be drawn to neurodevelopmental and disruptive, impulse-control, and conduct psychiatric disorders.

3.4.1.1 Neurodevelopmental disorders

Neurodevelopmental disorders are categorised as disabilities which manifest in early development and are associated with the neurological system and brain functioning (Mullin, Gokhale, Moreno-De-Luca, Sanyal, Waddington & Faundez, 2013: 329; DSM-5, 2013:31). These impairments are experienced in personal, academic, occupational, and social functioning (Salters-Pedneault, 2018:1). The DSM-5 (2013:31) stipulates that neurodevelopmental deficits range from broad impairments in social skills and intelligence to specific limitations, such as impaired learning or control of the executive function.

ASD, ADHD, LD and IDD are amongst the most prevalent neurodevelopmental disorders in children (Lein, 2015:3-20). Symptoms of these disorders often co-exist. It is of significance to this study to outline that the cause of the neurodevelopmental disorder is a result of gene-environment interaction (Lein, 2015:3-20). The DSM-5 (2013:32-33) outlines that, during the diagnostic process of a neurodevelopmental disorder, the use of a specifier, namely genetic or environmental, is of importance to identify the aetiology of the disorder for the appropriate treatment protocol.

3.4.1.2 Disruptive, impulse-control, and conduct disorders

Disruptive, impulse-control, and conduct disorders are categorised by behavioural and emotional self-control problems; which violate the rights of others (DSM-5, 2013: 461). The manifestation of these disorders emerges as aggressive outbursts against people and/or property and is more extreme and frequent than typical behaviour, thereby causing these individuals to come into conflict with figures of authority (Parekh, 2018:1).

Disruptive, impulse-control, and conduct disorders occur in various settings, under several forms, which include impulsive, defensive, and/or premeditated aggression (Parekh, 2018:1; Grant & Leppink, 2015:29-36). ODD, CD, intermittent explosive disorder, kleptomania, pyromania, anti-social personality disorder and other associated disorders, are prevalent disorders classified under the category of disruptive, impulse-control, and conduct disorders (DSM-5, 2013:461; Parekh, 2018:1). Although this study focuses on the influence of ODD and CD on child offenders suffering from psychiatric disorders, the differentiation made for diagnostic purposes, pertaining to ODD, CD and intermittent explosive disorder, will be briefly discussed in order to identify levels of severity of these disorders.

The DSM-5 (2013:461) makes a clear distinction between the severity of emotional and behavioural self-control, in relation to the diagnostic criteria for each disorder. For example, due to poor self-control of emotions, such as anger, and behaviour, such as aggression, a primary characteristic of CD is a violation of the rights of others or societal norms (DSM-5, 2013:461). On the other hand, intermittent explosive disorder is also characterised by poor self-control of emotions and behaviour, yet the outbursts of anger are disproportionate to the provocation or psychosocial stressor (DSM-5, 2013:461). Individuals suffering from intermittent

explosive disorder exhibit extreme aggression. ODD is intermediate in levels of severity, in comparison to the CD and intermittent explosive disorder. This disorder is classified with less extreme emotions, namely anger and irritation, and behaviour, namely, argumentative, and defiant (DSM-5, 2013:461).

A primary characteristic that links these disorders together is incessant risk-taking behaviour which is harmful to oneself and to others (Lliades, 2014:1). Underlying causes of difficulties in emotional and behavioural self-control vary with each disorder (DSM-5, 2013: 461). Prevalent environmental influences known to increase susceptibility to disruptive, impulse-control, and conduct disorders include physical and/or sexual abuse, parental neglect or harsh parenting, and/or parents with a criminal history (Grant & Leppink, 2015:29-36).

It is of interest to note, treatment protocols, by Parekh (2018:1), a medical practitioner from the American Psychiatric Association, outlined, "...medications are generally not used to directly treat conduct disorders...however, medications may be used for other conditions that frequently occur along with the conditions". Lliades (2014:1) opines that a holistic approach is needed in order to treat children suffering from disruptive, impulse-control and conduct disorders. Children suffering from these disorders experience a behavioural addiction, as experienced by one suffering from substance abuse disorder (Lliades, 2014:1). Thus, to improve emotional and behavioural self-control, treatment ought to focus on the emotional and behavioural compulsion, craving and the loss of control experienced. Treatment can be effective by addressing the characteristics and symptoms of the disorder, which will be discussed below.

In the section below, symptoms and characteristics of neurodevelopmental and disruptive, impulse-control, and conduct disorders will be explored in detail. It is important to emphasise that the DSM-5 (2013: 62, 471-474) makes clear reference to the diagnosis of a neurodevelopmental and disruptive, impulse-control, and conduct disorder pertaining to the context in which the behaviour occurred. This is a factor which must be taken into consideration, in terms of the diagnosis, since there may be a cultural variation in terms of interpreting a child's behaviour. This consideration is especially important for children suffering from disruptive, impulse-control, and conduct disorders, since defiant behaviour may be as a result, or

reaction to external environment, or learned behaviour (Paniagua, 2018:4). As mentioned above, the ICD-10 (2015) does not include factors, such as acculturation in the diagnostic schedule; which implies that taking cultural context into consideration is not a prerequisite when determining the extent of behaviour and making a diagnosis. Although the DSM-5 (2013) was created in an American context, the importance of taking acculturation into consideration is identified and South African child justice medical practitioners should, therefore, adopt an Afrocentric approach, by applying the South African context, when dealing with this vulnerable group of children.

In the sections to follow, the diagnostic features for ADHD, IDD, LD, ODD and CD will be presented.

- **Attention deficit hyperactivity disorder (ADHD)**

ADHD is one of the most prevalent neurodevelopmental disorders, which affects learning abilities, behaviour, and mental processing (Schellack, Meyer & Chigome, 2017: 28). According to Sue, Sue, and Sue (2010:423), children who suffer from ADHD manifest socially disruptive behaviour, either with impairing levels of hyperactivity and/or inattentiveness which inhibit their basic functioning in daily activities. ADHD is found to affect 5.29 per cent of children globally and approximately 5.4 to 8.8 per cent of children in African countries (Smith, 2017: 767-787; Chinawa, Odetunde, Obu, Chinana, Bakare & Ujunwa, 2014:1-6).

According to research (Bhoge et al, 2017:194; Olashore et al, 2017:1; Atilola et al, 2015:2), ADHD is prevalent in Botswana, Namibia and South Africa and is found to have an influence on school performance, susceptibility to substance abuse and conflict with figures of authority (Bhoge et al, 2017:194; Olashore et al, 2017:1; Atilola et al, 2015:2). Afolabi (2016:1) outlines that, ADHD is a neurodevelopmental disorder which is influenced by biological, pre-natal and psychosocial environmental factors. Common comorbidities of ADHD include anxiety, LD, disruptive, impulse-control, and conduct disorders, tics/Tourette's syndrome, depression, and substance abuse (Schellack et al, 2017:29).

There are three types of ADHD: predominantly hyperactive-impulsive type, predominantly inattentive type, and the combination type, characterised by hyperactivity and inattentiveness (DSM-5, 2013:60). Children diagnosed with a predominantly hyperactive-impulsive type of ADHD are accident prone, struggle with poor self-control, poor attention, are increasingly fidgety and have difficulty making friends (Sue et al, 2010:423; Munoz-Silva & Lago-Urbano, 2016:1-3). These children exhibit defiant and challenging behaviour. Children suffering from the inattentive type of ADHD are introverted, anxious and have trouble completing tasks, sustaining focus, and paying attention to detail (DSM-5, 2013:60; Sue et al, 2010:423-424). These children do not exhibit defiant behaviour, as found in children suffering from the hyperactive type of ADHD. Children diagnosed with ADHD combined suffer from hyperactivity and inattentiveness (DSM-5, 2013:60; Sue et al, 2010:423-424). These children are temperamental, socially, and emotionally immature, hostile, insensitive and are prone to risk-taking behaviour (Schellack et al, 2017:15; DSM-5, 2013: 60).

To diagnose ADHD the child's behaviour must be inconsistent with his age and developmental levels and should negatively affect social and/or academic functioning (DSM-5, 2013:59). Children, 12 years of age and younger, and/or adolescents, 13 to 17 years of age, must present six or more characteristics of inattention and/or hyperactivity. Young adults/adults, 18 years of age and older, must present five or more characteristics, for a period of at least six months (DSM-5, 2013:59-60). The child/ adolescent/ and/ or adult must be symptomatic in multiple contexts, such as home, school, work, and/or general social settings (e.g. park, mall, and restaurant) (DSM-5, 2013:32). The characteristics of inattention and/or hyperactivity is characterised by the following behaviour, outlined in the table below (DSM-5, 2013:59-60).

TABLE 1: DIAGNOSTIC CRITERIA FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

1. INATTENTION	2. HYPERACTIVITY AND IMPULSIVITY
<p>a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).</p>	<p>a. Often fidgets with or taps hands or feet or squirms in seat.</p>
<p>b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).</p>	<p>b. Often leaves the seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).</p>
<p>c. Often does not seem to listen when spoken to directly (e.g., the mind seems elsewhere, even in the absence of any obvious distraction).</p>	<p>c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless).</p>
<p>d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily side-tracked).</p>	<p>d. Often unable to play or engage in leisure activities quietly.</p>
<p>e. Often has difficulty organising tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping</p>	<p>e. Is often 'on the go', acting as if 'driven by a motor' (e.g., is unable to be or uncomfortable being still for an</p>

materials and belongings in order; messy, disorganised work; has poor time management; fails to meet deadlines).	extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).	f. Often talks excessively.
g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).	g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for a turn in conversation).
h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).	h. Often has difficulty waiting for his or her turn (e.g., while waiting in line).
i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).	i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

(Source: DSM-5, 2013:59-60).

As outlined, short attention span, impulsivity, poor self-control, and hyperactivity are a few of the primary characteristics of ADHD (DSM-5, 2013:59-60). Resulting from these characteristics, children suffering from this disorder experience poor cognitive

and conative functioning manifested as socially inappropriate behaviour, emotional immaturity, difficulty understanding social cues and the consequences of actions (Sue et al, 2010: 422-425; Austin et al, 2014:515). Research (Duggal & Legg, 2016:1) indicates that children suffering from ADHD have an underdeveloped frontal lobe and exhibit lower levels of dopamine, which is a neurotransmitter that carries responses to the brain, specifically for emotional regulation dealing with pleasure, reward and pain responses, cause, and effect, and understanding social cues. Due to the behavioural manifestation, children suffering from ADHD are therefore susceptible to risk-taking behaviour, which can bring them into conflict with the law (Afolabi, 2016:1; Bhandari, 2016:1).

According to section 11 of the Child Justice Act factors pertaining to cognitive and conative functioning are significant when determining criminal capacity and appropriate treatment for a child in conflict with the law. Deduced from the above discussion, it is imperative for child justice practitioners to take the cognitive and conative functions of a child suffering from ADHD into consideration.

ADHD is amongst the prevalent childhood neurodevelopmental disorder found to affect children in African countries (Chinawa et al, 2014:1-6; Smith, 2017: 767-787). In addition to the biological factors, namely poor cognitive and conative functioning, which pre-dispose the child to risk-taking behaviour; environmental factors have an equal contribution to the development of criminal behaviour in children suffering from ADHD.

It must be acknowledged that not all children suffering from ADHD are likely to develop criminal behaviour. However, in light of the fact that research has established a causal link between psychiatric disorders and criminality, the influence of the disorder on the child's criminal behaviour and criminal capacity should be taken into consideration in the child justice system in order to ensure the best interest of the child as stipulated in the preamble of the Child Justice Act. As outlined above, children suffering from ADHD often experience comorbid conditions, such as LD, IDD and disruptive, impulse-control, and conduct disorders (Schellack et al, 2017:29). In the section below, the characteristics, symptoms, and the influence of IDD on children will be explored.

- **Intellectual developmental disorder (Intellectual disability) (IDD)**

Children suffering from IDD experience deficits in general mental functioning, such as the ability to reason, plan, perceive and judge social situations and solve problems (Austin et al, 2014:528). Based on the neurological impairments experienced, IDD is categorised as a neurodevelopmental disorder (DSM-5, 2013:31). IDD affects 1.83 per cent of children worldwide and 0.27 per cent of South African's, including children (Speech and Language Association, 2018:1; Adnams, 2010:437). According to the South African College of Applied Psychology (2015:1), four out of every 100 South Africans, children included, are affected by some form of intellectual impairment and the consumption of alcohol during pregnancy is one of the leading causes of IDD in South Africa (South African College of Applied Psychology, 2015:1).

The task of diagnosing children with IDD can be increasingly challenging (South African College of Applied psychology, 2015:1). This is because some children suffering from IDD have physical abnormalities, whilst others only experience behavioural and mental processing issues. The degree of IDD varies and common causes of this disorder include, brain injury, premature birth, severe malnutrition and/or substance abuse during pregnancy (Lima-Rodriguez, Baena-Ariza, Dominguez-Sanchez & Lima-Serrano, 2018: 89-90). For a diagnosis of IDD to be made, the individual must present with the following three criteria (DSM-5, 2013:33):

TABLE 2: DIAGNOSTIC CRITERIA FOR INTELLECTUAL DEVELOPMENTAL DISORDER (IDD)

<p>A. Deficits in intellectual functions, such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.</p>	<p>B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.</p>	<p>C. The onset of intellectual and adaptive deficits during the developmental period.</p>
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(Source: DSM-5, 2013:33).

Studies conducted by the American Academy of Child and Adolescent Psychiatry (2013:1) outline that due to mental and emotional deficits, children suffering from IDD are often aware of their impairments and act-out due to frustration, stress, and anxiety. Mental deficits affect the cognitive and conative functions and therefore result in the child's inability to fully appreciate the impact of his behaviour. Children suffering from this disorder are also pre-disposed to depressive and disruptive, impulse-control, and conduct disorders (American Academy of Child and Adolescent Psychiatry, 2013:1).

In addition to the frustration and stress experienced, environmental factors are often found to exacerbate the characteristics of IDD and therefore create an environment where the child becomes susceptible to criminal behaviour. Deduced from this discussion, it is therefore vital that an integrated approach, which takes into

consideration the cognitive and conative functions and the influence of the environment, should be used when dealing with a child offender who suffers from a psychiatric disorder, such as IDD.

It must also be acknowledged that, according to the Criminal Procedure Act Amendment Bill (2017:13), the term 'mental defect', referring to persons suffering from a mental defect in terms of criminal capacity, will be replaced with 'intellectual disability'. Although these changes will be explored in detail in chapter 4, it is important to discuss the hurdles created by conflicting legal terms in various bodies of legislation.

The concern which arises specifically from this legislative amendment, in sections 78(1), 78(1A) and 78(2) of the Criminal Procedure Act is that, persons/ children suffering from a psychiatric disorder, such as ADHD, ODD or CD, may not fall into the category of 'intellectual disability', in terms of defining an actual intellectual disability. Thus, the extent to which the influence of psychiatric disorders, such as ADHD, ODD and CD, will be factored in when one is to determine the criminal capacity of this group of child offenders, is questionable. As mentioned, these changes and the application pertaining to child offenders suffering from psychiatric disorders will be explored in chapter 4.

- **Specific learning disorder (Learning disorder) (LD)**

The DSM-5 (2013:66) outlines LD as a neurodevelopmental disorder that influences the cognitive functioning and behaviour of the child. Approximately 10 to 30 per cent of children suffer from some form of LD (Normand & Vermoter, 2011: 1). Statistics reveal that approximately 40 per cent of children suffering from LD drop-out of school and manifest behavioural as well as emotional problems (Normand & Vermoter, 2011:1). Additionally, individuals suffering from LD reflect an intelligence of average to above average but have trouble with specific learning aspects and are unable to learn effectively through conventional learning techniques (Normand & Vermoter, 2011:1).

Children with LD experience impairments, which affect auditory, verbal, mathematical, visual perception, written expression, language processing and interpretation of the environment (Johnson, 2015:1). Upon diagnosis, one of these

impairments also referred to as specifiers or domains, will be identified and the degree - mild, moderate, or severe - will be indicated (DSM-5, 2013: 67). Mild cases of LD occur where learning disabilities are exhibited in two academic domains and the child is able to function with assistance and support (DSM-5, 2013:67). In moderate cases, learning disabilities are exhibited in one or more academic domain but the child requires intensive, specialised tutoring assistance in order to complete scholastic activities correctly (DSM-5, 2013:67). In severe cases of LD, the child experiences learning disabilities in several academic domains and may fail to complete scholastic activities, even with specialised tutoring assistance (DSM-5, 2013:67).

For a diagnosis of LD to be made, the individual must present with at least one of the following symptoms (despite interventions to improve), under the criteria outlined below, for a period of six months or longer (DSM-5, 2013:66-67):

A. Difficulties learning and using academic skills

- Inaccurate or slow and effortful word reading (e.g. reads single words aloud incorrectly or slowly and hesitantly, often guesses words, has difficulty sounding out words).
- Difficulty understanding the meaning of what is read (e.g. may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read).
- Difficulties with spelling (e.g. may add, omit, or substitute vowels or consonants).
- Difficulties with written expression (e.g. makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of ideas lack clarity).
- Difficulties mastering number sense, number facts, or calculation (e.g. has a poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).

- Difficulties with mathematical reasoning (e.g., has severe difficulty in applying mathematical concepts, facts, or procedures to solve quantitative problems).
- B. The affected academic skills are substantially and quantifiably below those expected for the individual's chronological age and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals age 17 years and older, a documented history of impairing learning difficulties may be substituted for the standardized assessment.
- C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual's limited capacities (e.g. as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads).
- D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction.

According to the Eunice Kennedy Shriver National Institute of Child Health and Human Development (2016:1), children who suffer from LD experience inattentiveness, difficulty with basic memory, coordination, and poor time management. These children manifest impulsive, inappropriate behaviour and struggle with adapting to new situations (Eunice Kennedy Shriver National Institute of Child Health & Human Development, 2016:1). In the context of this study, functional consequences experienced by children suffering from LD can lead to the development of comorbid psychiatric disorders, such as ADHD, as well as conflict with figures of authority. As a result of the behavioural characteristics, there is a strong relationship (approximately 30%) between children in the juvenile justice system and LD (Raskind, 2015:1). It is therefore essential to conduct a comprehensive evaluation to determine the overall profile of strengths and weakness experienced to effectively provide treatment for a child suffering from LD (Johnson, 2015:1).

- **Oppositional defiant disorder (ODD)**

The American Academy of Child and Adolescent Psychiatry (2017:1) outlines that children who suffer from ODD manifest “...an ongoing pattern of uncooperative, defiant, and hostile behaviour towards figures of authority...” Primary characteristics of ODD include, but are not limited to defiant behaviours, such as temper tantrums, argumentative behaviour, refusal to follow instructions from adults or figures of authority, and irresponsibility (Pardini & Fite, 2011:1; Sue et al, 2010:426). This type of behaviour negatively affects the child’s daily functioning and pre-disposes him to substance abuse, truancy, and conflict with the law (Pardini & Fite, 2011:1; Sue et al, 2010:426). As outlined above, the DSM-5 (2013: 461) categorises ODD as a disruptive, impulse-control, and conduct disorder.

ODD is found to affect 3 to 11 per cent of the world population and affects more boy than girl children (Vlok, 2016:1). According to Kandola (2018:1), the causes of ODD are identified as multi-dimensional, i.e. environmental, genetic, and developmental. The symptoms of this disorder are found to overlap and co-exist with other childhood psychiatric disorders, such as ADHD, LD, mood, and anxiety disorders (Bhandari, 2016:1). The severity of ODD varies from mild (symptoms expressed in specific setting only), moderate (symptoms expressed in at least two different settings) and severe (symptoms are expressed in three or more settings) (Kandola, 2018:1).

For a diagnosis of ODD to be made, the child must present with four or more symptoms for a period of six months or more, with at least one individual, other than a sibling (DSM-5, 2013:462-464):

TABLE 3: DIAGNOSTIC CRITERIA FOR OPPOSITIONAL DEFIANT DISORDER (ODD)

ANGRY/IRRITABLE MOOD	ARGUMENTATIVE/DEFIANT BEHAVIOUR	VINDICTIVENESS
1. Often loses temper.	4. Often argues with authority figures or, for children and adolescents, with adults.	8. Has been spiteful or vindictive at least twice within the past 6 months.
2. Is often touchy or easily annoyed.	5. Often actively defies or refuses to comply with requests from authority figures or with rules.	
3. Is often angry and resentful.	6. Often deliberately annoys others.	
	7. Often blames others for his or her mistakes or misbehaviour.	

(Source: DSM-5, 2013:426).

The characteristics and symptoms of ODD, namely aggression, defiance and hostility are clear pre-cursors which pre-dispose the child to coming into conflict with figures of authority (Pardini & Fite, 2011:1; Sue et al, 2010:426). As a result of these characteristics, children suffering from this disorder experience significant impairment in academic and social functioning, as outlined above (Sue et al, 2010:426). The aetiology of this disorder is an interaction between psychological, genetics, socio-cultural and socio-familial factors (Kandola, 2018:1; Sue et al, 2010:426).

In respect to the severity of disruptive, impulse-control, and conduct disorders; ODD is considered to be intermittent (DSM-5, 2013: 461). Children suffering from ODD,

who reflect an increase in levels of defiance, aggression and hostility convey risk factors for the development of CD (DSM-5, 2013: 464). In the section below, the diagnostic criteria for CD are discussed.

- **Conduct disorder (CD)**

Children and adolescents, who suffer from CD, experience impaired psychological, emotional, social, and cognitive functioning (DSM-5, 2013:474). The impact of CD not only affects the child, but the family, school, peers, and community (Royal College of Psychiatrists, 2014:1). Behavioural problems occur during child- and adolescent hood and it is important to note that not all children who display disruptive or defiant behaviour are candidates for a diagnosis of ODD or CD. According to Trytsman (2016:6-7) and Boezaart and Skelton (2011:3), children who suffer from disruptive, impulse-control, and conduct disorders, such as CD, portray more violent, physical aggression, poor academic skills, school truancy, expulsion, anti-social, risk-taking behaviour as well as substance abuse. This disorder is found to negatively affect children and adolescents more severely and chronically, in comparison to most other psychiatric disorders (DSM-5, 2013:474). CD is found to affect approximately 16 per cent of children internationally (Mental Health America, 2016:1). It is of significance to highlight that due to a dearth of research, there were no recent statistics pertaining to the prevalence of CD in South African children.

For a diagnosis to be made, the child/adolescent must present with at least three characteristics, from criteria A in the past 12 months, and at least one characteristic in the past six months. It is of significance to highlight specifiers, such as lack of remorse or guilt, callousness and lack of empathy, shallow or deficient affect and unconcern about performance, for a diagnosis of CD, since these factors are prevalent in child offenders suffering from CD (DSM-5, 2013: 470-472), The criteria for diagnosis is reflected in the table below (DSM-5, 2013:470):

TABLE 4: DIAGNOSTIC CRITERIA FOR CONDUCT DISORDER

A. AGGRESSION TO PEOPLE AND ANIMALS	DESTRUCTION OF PROPERTY	DECEITFULNESS OR THEFT	SERIOUS VIOLATIONS OF RULES
1. Often bullies threatens or intimidates others.	8. Has deliberately engaged in fire setting with the intention of causing serious damage.	10. Has broken into someone else's house, building, or car.	13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
2. Often initiates physical fights.	9. Has deliberately destroyed others' property (other than by fire setting).	11. Often lies to obtain goods or favors or to avoid obligations (i.e., 'cons' others).	14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).		12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)	15. Is often truant from school, beginning before age 13 years.

4. Has been physically cruel to people.			
5. Has been physically cruel to animals.			
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).			
7. Has forced someone into sexual activity.			

(Source: DSM-5, 013:470-473).

Aggression towards people and animals, destruction of property and serious violations of the law are the primary factors found in a child suffering from CD (DSM-5, 2013: 470-473). As similarly outlined above, the behavioural characteristics manifested by children suffering from disruptive, impulse-control, and conduct disorders, and more specifically children who manifest with the aforementioned specifiers, are pre-disposed to coming into conflict with the law. When arguing the criminal capacity of child offenders suffering from CD, factors such as limited pro-social emotions, lack of remorse, lack of empathy and shallow or deficient affect are factors which may indicate that, a child offender suffering from CD, may have chosen to behave in a defiant and aggressive manner, rather than being a victim of his circumstances, or impulsivity. However, a counter-argument in this respect, which child justice practitioners need to take into consideration is, it is essential to consider the context and circumstances which caused the child to behave in that manner.

This does not excuse the wrongful behaviour, but it implies that in order to treat this group, one needs to consider the factors which caused the child to develop defiant and aggressive behaviour, or a lack of empathy, instead of only focusing on the criminal offence.

Thus, to ensure that the child is receptive to methods used, a holistic approach, which addresses biological, social, psychological and environmental factors, is recommended for dealing with child offenders suffering from psychiatric disorders, such as ODD and CD.

The symptoms and behavioural characteristics exhibited by children suffering from neurodevelopmental and disruptive, impulse-control, and conduct disorders are found to have negative consequences on the daily, academic, social, familial, and personal functioning of the child, as discussed above (DSM-5, 2013: 33, 59,60,66-67, 462,470-473). Factors such as, impulsivity, inattention, defiance, aggression, hostility and poor social skills, which are prevalent symptoms and characteristics of ADHD, ODD, CD, IDD and LD, are found not only to cause but also exacerbate the child's risk of coming into conflict with figures of authority (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016:168-169). In addition to the neurodevelopmental and behavioural difficulties experienced by children suffering from these disorders, it is essential to take into consideration the environmental and social factors which worsen the psychiatric disorder and influence criminal behaviour in children living in African countries. As mentioned, for the purpose of this study, the focus will be drawn to Namibia, Botswana, Nigeria, and South Africa.

In the section below, the prevalence of psychiatric disorders amongst children residing in Africa is discussed.

3.5 THE PREVALENCE OF PSYCHIATRIC DISORDERS IN CHILD OFFENDERS IN AFRICA

There is a dearth of research on the prevalence of child offenders with psychiatric disorders in Africa. Findings from studies conducted on children in conflict with the law in Nigeria (Bella et al, 2010:1; Olashore et al, 2016), Namibia (Heita, 2015), Botswana (Olashore et al, 2017) and South Africa (Sommer et al, 2017: 29-34;

Paruk & Karim, 2016:548-550), all however concur that factors such as poverty, limited educational opportunities and poor physical and mental health services, increase a child's susceptibility to juvenile delinquency and psychiatric disorders. This in-turn emphasises the need for increased mental health care for children in Africa.

According to the findings from the studies highlighted above, although Africa has made great strides in child justice legislative development, since the ratification of the UNCRC (1990) by many African nations, research reflects that there are still areas of concern in legislation and methods of practice, and a scarcity of effective needs-based services for child offenders with psychiatric disorders. In addition to the ratification to the UNCRC (1990), it is important to highlight South Africa's ratification of the ACRWC (1990), since it emphasises the rights of children in African countries.

3.5.1 Nigeria

Many Nigerian children are subjected to dysfunctional and disruptive family structures, child maltreatment and exposure to negative environmental circumstances which increase their susceptibility to delinquent behaviour (Bella et al, 2010:1). There is a high incidence of children in conflict with the law in Nigeria. The Nigerian prison services, in Kaduna, Ilorin and Abeokuta disclosed that in 2017, approximately 938 minors were imprisoned for drug trafficking and dealing, theft and other criminal offences (Anon, 2017:1). As a result of the high incidence of children in conflict with the law, Nigeria implemented a diversion community rehabilitation programme to reduce the risk of recidivism (United Nations International Children's Emergency Fund¹, Child Justice in Nigeria, 2017:1). Children who find themselves in conflict with the law are dealt with in terms of the Children and Young Persons Law of Nigeria (1990) which is more fully discussed in chapter 4.

There is also a high incidence of children suffering from mental disorders in Nigeria. According to a study conducted by Atilola, Ayinde, Emedoh and Oladimji (2015), childhood mental health issues are an international concern and approximately 13 to 20 per cent of children in Nigeria suffer from mental health disorders. Psychiatric disorders such as ADHD, anxiety, depression and disruptive, impulse-control, and conduct disorders were identified as the most prevalent disorders amongst children.

¹ United Nations International Children's Emergency Fund (hereafter referred to as UNICEF).

Findings from this study (Atilola et al, 2015:2) also indicate that there were no recent statistics pertaining to the incidence of children suffering from mental health issues in the country and this was identified as a gap in research requiring attention.

For this study, two bodies of research on delinquent children, conducted by Olashore et al (2016) and Bella et al (2010) were explored. The findings from both studies (Olashore et al, 2016 & Bella et al, 2010) concurred that there was a high incidence of psychiatric disorders present in children in conflict with the law. Olashore et al (2016) conducted a cross-sectional descriptive study on the incidence of CD among 147 adolescent offenders in the Nigerian Borstal Institution. Data was collected using a self-administered questionnaire and a neuropsychiatric interview, namely MINI-KID (Olashore et al, 2016:1). Similar to findings from a Botswanan study (Heita, 2015:1), Olashore et al (2016:1) found a high incidence of CD (56.6%) among adolescent offenders. Findings from Olashore et al (2016:01) highlight the association between CD, large family size and criminal recidivism. Here, suggestions were made towards the development and implementation of comprehensive early interventions which focus on promoting parental supervision and reducing recidivism (Olashore et al, 2016:1).

Similarly, Bella et al (2010:1) conducted research on 59 incarcerated children in a remand home in Ibadan, Nigeria. The aim of this study was to develop and potentially provide comprehensive services for incarcerated children. A cross-sectional survey was conducted, using a semi-structured interview schedule to collect data, on the psychosocial needs and distinct types of psychopathology found in this group of children. Findings from this study (Bella et al, 2010:1) reflected that the majority (90%) of children were found to be in need of care and protection. As will be discussed in chapter 4, children in need of care and protection in Nigeria are classified as children who are vulnerable, who have been abused, who have experienced malnutrition and/or who are homeless (Children's and young persons' law of Nigeria, 1990, part 5). Findings from this study (Bella et al, 2010:1) also reflected that the majority (97%) of children presented with psychopathology, anxiety, and depressive symptoms. The entire sample reflected the need for primary support and economic, environmental, social, educational, and psychosocial intervention (Bella et al, 2010:1). Similar to findings from Olashore et al (2016:1),

Bella et al (2010;1) are of the opinion that incarcerated children reflect significant mental health issues which need to be addressed by a collaborative effort of child care health professionals.

Although Nigeria has made progress in services, the procedures used to deal with child offenders, which are discussed in Chapter 4, factors pertaining to children with psychiatric disorders, and more so child offenders with psychiatric disorders, require a great deal of attention in order to improve on services available to this group of children.

3.5.2 Namibia

In 2016, Namibia's prison population was estimated at 7400 pre-trial detainees and remand prisoners; of which approximately 0.2 per cent consisted of child offenders (The Institute for Criminal Policy Research, 2018; 1). In a similar study to that of Olashore et al (2016), Heita (2015: 1) documented that the Namibian juvenile system has shown an increase of over 4000 adolescent offenders in the past four years. According to two different news articles (Neidel, 2014; Heita, 2015), the rise in juvenile delinquency in Namibia is a concern. Children who come into conflict with the law in Namibia are protected and dealt with under the Namibian Constitution (1998), Child Care and Protection Act (2015) and Criminal Procedure Act of Namibia (2004), which are discussed in detail in chapter 4.

Amidst plans to implement juvenile rehabilitation institutions in Namibia, children in conflict with the law are still detained in adult prisons, although in separate sections (Winterdyk, 2013:1). These facilities do not have correctional staff trained to deal with young offenders (Winterdyk, 2013:1).

The influence of CD was highlighted as one of the major causes of substance abuse and physical assault among school peers (Heita, 2015:1). Findings from Heita (2015;1) highlighted that this vulnerable group of children are exposed to negative environmental circumstances; such as broken families and poor socio-economic circumstances which increase their susceptibility to criminal activity (Heita, 2015:1). This article (Heita, 2015:1) concluded with suggestions to move away from forms of punishment and to move rather towards improved rehabilitation programmes that focus on more home-visits from probation officers, cognitive processing and

stimulation and more individualised after-care treatment protocols, that attend to the child's specific needs (Heita, 2015:1).

In addition to children coming into conflict with the law, and for the purpose of this study, the incidence of children with mental health issues in Namibia is of significance. According to the Namibian National Policy for Mental Health (2018:5) approximately 3600 to 7200 (0.51 %) of children, younger than 15 years of age, suffer from serious mental health problems, and approximately 6600 (1%) of children, younger than 15 years of age, suffer from neurodevelopmental and disruptive, impulse-control, and conduct disorders. Government mental health services, for both children and adults, are available at the Windhoek Mental Health Care Centre and the Oshakati Psychiatric Unit (Namibian National Policy for Mental Health, 2018:5).

According to the findings from the Namibian National Policy for Mental Health Report (2018:7), mental health services still require a great deal of attention and development in order to address and meet the needs of persons suffering from mental health issues. Currently, there is a lack of skilled mental health professionals, poor diagnostic tools, limited services and poor understanding and awareness of mental health issues, which hamper the quality of service provided to both adults and children (Namibian National Policy for Mental Health, 2018:7). It is evident from the literature reviewed that, although Namibia has made provision towards developing methods used to deal with child offenders with psychiatric disorders, the implementation and practice hampers the protection of these children.

3.5.3 Botswana

The Institute for Criminal Policy Research (2018; 1) indicates that the total prison population in Botswana is approximately 4343 pre-trial detainees and remand prisoners; and of this, 10.4 per cent consists of children. According to a news article (Anon, 2018:1), Botswana is facing an increase in juvenile delinquency and is "...ill-equipped to handle the growing juvenile crime and delinquency..."

In addition to the incidence of children in conflict with the law, Raditsebe (2017:1) indicated that there is a growing incidence of children suffering from depression and other psychiatric disorders in Botswana. Olashore et al (2017:1) conducted a

longitudinal study in Sbrana Psychiatric hospital on the prevalence of psychiatric disorders and predictors of treatment outcome. The sample used in this study included children and adolescents (under 17 years of age). This sample did not include delinquent children but provided a statistical overview of the incidence of children suffering from psychiatric disorders in Botswana, which is of significance to this study.

Findings from this study (Olashore et al, 2017:1) outlined that ADHD was the most prevalent diagnosed psychiatric disorder (25%) amongst children in Sbrana psychiatric hospital. Children, between 5 and 9 years of age, had a high incidence of ADHD (60%) and ASD (58.3%), while children, between 14 and 17 years of age, had a high incidence of psychosis (80%) and depression (88.9%) (Olashore et al, 2017:1). Based on the findings from this study, Olashore et al (2017:1) highlighted the need for further research in and development of specialised mental health care services to improve the quality of life for children suffering from mental disorders and to assist them in their home environments.

In addition to dealing with child offenders, Botswana, Nigeria, and Namibia face the challenge of dealing with and providing services to child offenders with psychiatric disorders. To meet the best interest of the child, it is essential to individually address the risk, causative and pre-disposing factors influencing the development of psychiatric disorders and criminal behaviour for these children. This complex task requires a trans-disciplinary approach from a multi-dimensional team of child justice experts. Here, good, and effective practices can be applied, from a holistic perspective, for dealing with this group of vulnerable children. Against the background of the aforementioned studies, highlighting the incidence of children in conflict with the law, and children suffering from psychiatric disorders in Botswana, Nigeria and Namibia; it is evident that there is a scarcity of practical child justice development specifically geared towards child offenders suffering from a psychiatric disorder(s). To improve the services available to child offenders, as well as child offenders suffering from psychiatric disorders, extensive research is needed to provide a clear indication of how these countries can implement improved service-delivery.

3.5.4 South Africa

Since the implementation of the Child Justice Act in 2008,² South Africa has made progress in dealing with child offenders, both those who suffer from psychiatric disorders as well as those who do not. According to the DOJ&CD Annual Report (2017:106), a total of 7673 children came into conflict with the law between 2016 and 2017. Although out of the scope of this study, statistics reflect a decrease in the number of children in conflict with law between 2014 (7946) and 2017 (7673) (DOJ&CD, Annual report, 2017:34,106).

In addition to the issue of children coming into conflict with the law in South Africa, challenges pertaining to the incidence of children suffering from psychiatric disorders are of significance. Statistics from the South African Depression and Anxiety Group (2016:1) reflect that more than 17 per cent of South African children suffer from mental illnesses. A few of the predominant causes of mental health disorders, in both adults and children, include poverty, maltreatment, exposure to substance abuse, violence, trauma and a stressful living environment (South African Depression and Anxiety Group, 2016:1).

Sommer et al (2017: 29-34) conducted a study on the impact of traumatic events, post-traumatic stress disorder, symptom severity, aggression, committed offences and substance abuse on 290 male South African adolescents. The adolescents were recruited from a re-integration centre in Cape Town. Findings from this study positively linked exposure to trauma, post-traumatic stress disorder, symptom severity and substance abuse to increased criminal activity (Sommer et al, 2017:29-34). These findings highlight the clear association between child maltreatment and criminal activity.

According to Paruk and Karim (2016:548-550), approximately 20 per cent of children and adolescents suffer from a mental disorder and approximately half of the mental health disorders and substance abuse related disorders begin at 14 years of age. Paruk and Karim (2016:548) conducted research on children, 15 to 19 years of age, in five different cities in South Africa. This study provided a reflection of the prevalent psychiatric disorders affecting children in the general population in South Africa and

² The implementation of the Child Justice Act will be discussed in chapter 4.

was not specific to child offenders (Paruk & Karim, 2016:548). Findings from this study (Paruk & Karim, 2016:548) are similar to findings from research conducted in South Africa (Sommer et al, 2017:29-34), Nigeria (Bella et al, 2010:1) and Botswana (Olashore et al, 2017:1), in that anxiety, mood, trauma and stress-related disorders due to child maltreatment, were all highlighted as the most common disorders to affect children (Paruk & Karim, 2016:548).

Amidst the development and progress made in the South African child justice legislation, there is still a dearth of child justice research concerning the implementation of legislation and methods of practice used to deal with child offenders with psychiatric disorders.

TABLE 5: PREVALENT PSYCHIATRIC DISORDERS IN CHILDREN AND CHILDREN IN CONFLICT WITH THE LAW

<i>AUTHOR(S)/ YEAR</i>	<i>LOCATION</i>	<i>SAMPLE</i>	<i>MEASURES</i>	<i>MAJOR FINDINGS</i>
Olashore, Ogunwale & Adebowale (2016)	Nigerian Borstal Institution	147 adolescent offenders	Data was collected using a self-administered questionnaire and a neuropsychiatric interviewer, namely MINI-KID	The study found a high incidence (56.6%) of CD among the adolescent offenders. Olashore et al (2016:01) highlighted the association between CD, large family size and recidivism. Here, findings suggested the development and implementation of comprehensive early interventions which focus on promoting parental supervision and reducing recidivism (Olashore et al, 2016:1).

Heita (2015) News article	Namibia	Children in Namibia	Unspecified	<p>The influence of CD was highlighted as one of the major causes of substance abuse and physical assault among school peers (Heita, 2015:1).</p> <p>Children are exposed to negative environmental circumstances, such as broken families and poor socioeconomic circumstances which increase their susceptibility to criminal activity (Heita, 2015:1).</p> <p>Suggestions were made to move away from punishment and to rather move towards improved rehabilitation programmes that focus on home visits from probation officers, cognitive processing and stimulation and more individualised after-care treatment protocols, attending to the child's specific needs (Heita, 2015:1)</p>
Olashore, Frank-Hatitchi & Ogunwobi (2017:1)	Sbrana Hospital psychiatric hospital in Botswana	238 children admitted to Sbrana psychiatric hospital	Analysis of patient records and case files.	<p>Children, between 5 and 9 years of age, had a high incidence of ADHD (60%) and ASD (58.3%), while children, between 14 and 17 years of age, had a high incidence of psychosis (80%) and depression (88.9%) (Olashore et al, 2017:1).</p> <p>Based on the findings from this study, there is a need for research and development in specialised mental health care services for children suffering from mental disorders (Olashore et al, 2017:1).</p>

Geoffrey (2016)	South Africa (Kwa Zulu Natal, Eastern Cape, Western Cape & Pretoria)	Child justice experts (Psychologists, psychiatrists, social workers, Criminologist, Advocate, Academic Professors)	Semi-structured interviews	Psychiatric disorders, such as ADHD, ODD, CD, LD & ID, were found to be the most prevalent psychiatric disorders to influence and increase criminal activity in children (Geoffrey, 2016: 166-167). These disorders were also outlined as having an impact on the criminal capacity of the child. Environmental and societal factors were also found to increase the risk of psychiatric disorders as well as criminal behaviour and were highlighted as factors that need to be taken into consideration (Geoffrey, 2016: 167-168).
Sommer, Hinsberger, Elbert, Holthausen, Kaminer, Seedat, Madikane & Weierstall (2017: 29-34)	Cape Town, South Africa	290 male adolescents from a reintegration centre.	Structured clinical interviews	Findings from this study positively linked exposure to trauma and PTSD symptom severity, substance abuse and the number of criminal offences committed (Sommer et al, 2017:29-34).
Paruk & Karim (2016)	Johannesburg, South Africa	Children aged 15 to 19 years of age	Unspecified	Female adolescents reported to have the highest levels of depression (44.6%) and post-traumatic stress symptoms (67.0%). Anxiety, mood, trauma, and stress-related disorders, were all highlighted as most common and were all closely associated with the increase in the statistical rate of suicide (Paruk & Karim, 2016:548)

Bhoge, Panse, Pawar, Raparti, Ramanand & Ramanand (2017)	Not specified	50 boys (aged 6-16) from an observation home, Of the 50 juvenile boys, 20 were in conflict with the law and 30 were under care and protection.	Mini-International neuropsychiatric interview (MINI Kid version).	<p>The prevalence of psychiatric morbidity found children in conflict with the law was higher (19 out of 20) than children under care and protection (25 out of 30) (Bhoge et al, 2017: 192).</p> <p>The prevalence of CD was the highest for both children in conflict of law (70%) as well as children under care and protection (30%) (Bhoge et al, 2017:194).</p> <p>More than half (56%) of the combined sample namely, children under conflict of law and children under care and protection, suffered from substance abuse (Bhoge et al, 2017:194).</p>
Bella, Atilola, & Omigbodun (2010)	Ibadan, Nigerian	59 children from Ibandan Nigerian Remand home	Cross sectional survey using a semi-structured interview schedule	<p>The majority (90%) of children in the Ibandan Nigerian remand home were found to be children who are in need of care and protection.</p> <p>The majority of these children (97%) manifested anxious and depressed behaviour.</p>

It is apparent from the findings of the numerous studies discussed above, that there is a strong correlation between the influence of psychiatric disorders and delinquency. The content in this chapter outlines the prevalence of children, and child offenders, suffering from psychiatric disorders in certain African countries. Influential risk factors for the development of psychiatric disorders and criminal behaviour provide an explanation for the incidence of psychiatric disorders and criminal behaviour found in children in the selected African countries of comparison.

Against this background, it is evident that, in order for the child justice system to reduce recidivism and provide effective treatment to child offenders with psychiatric disorders, a holistic approach is needed. With this, all influential factors which place the child at risk of developing psychiatric disorders and criminal behaviour need to be taken into consideration. In the section to follow, factors pertaining to why the child justice system should be concerned with the influence of psychiatric disorders, and the need for a multi-disciplinary child justice team will be outlined.

3.6 THE INFLUENCE OF PSYCHIATRIC DISORDERS ON CHILDREN WHO ENTER THE CHILD JUSTICE SYSTEM

Research identifies a link between poor socioeconomic environments, exposure to violence and parental neglect, and the predisposition to develop psychiatric disorders and criminal behaviour (Neuman, 2015:1; World Health Organisation, 2015:1; Pelsier, 2008:4; Cortina et al, 2012: 276-281; Trollip, 2014:1; Ntsabo, 2018:1; Geoffrey, 2016:111, 16-167; Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550).

Austin et al (2014), highlighted how the influence of psychiatric disorders, on psychological and intellectual processing, impairs a child's ability for logical thinking, processing information, controlling impulses, and understanding social cues (Austin et al, 2014:513-514). This impaired ability will influence how the child perceives social situations, affect the child's cognitive processing of decision-making and subsequently alter the ability to practise self-control, i.e. the conative function.

According to Underwood and Washington (2016:228), due to the increase in identification of psychiatric disorders in child offenders, there has been an amplified

reliance on the juvenile justice system for treatment and specialised services. Within the past decade, child justice systems were presented with the challenging task of not only assessing and determining criminal capacity but also providing or referring the child to specialised facilities pertaining to his individualised psychiatric/psychological needs (Underwood & Washington, 2016:228). It must be acknowledged that factors influencing the development of a psychiatric disorder(s) and criminal behaviour, are not only necessary to determine the criminal capacity of child offenders suffering from psychiatric disorders but are also of significance in terms of determining risk factors for re-offending. Against the background of the criminological theoretical underpinnings discussed earlier, and the influential factors experienced in certain African countries; corrective measures applied in the child justice system (from a holistic perspective - biological, psychological, and environmental factors) for children with psychiatric disorders, are vital to ensure that the best interest of the child is upheld.

Although this study focuses on children suffering from neurodevelopmental as well as disruptive, impulse-control, and conduct disorders; emphasis must be placed on children suffering from disruptive, impulse-control, and conduct disorders and the lack of awareness from mental health practitioners. The fact that, because of the symptoms and characteristics of this disorder, this group of children are at an increased risk of coming into conflict with the law, is of concern since child justice and mental health practitioners do not acknowledge the seriousness of providing holistic treatment to this group of children (Geoffrey, 2016: 42, 160, 179; Besemer et al, 2017:161-178; McCord et al, 2017:70-71; Human, 2015:101).

According to the South African Constitution (section 28), the Children's Act (section 2, 11 & 150) and Child Justice Act (section 29 & 50), children in need of care and protection hold the right to receive basic health care and social services that pertain to their special needs. However, the scarcity of mental health practitioners was identified in that there are only 13000 psychologists serving more than 50 million people in South Africa (Ntsabo, 2018:1).

Due to the lack of services and service-providers that specifically deal with child offenders with psychiatric disorders, the rights of these children are violated. Psychological treatment requires a great deal of development and improvement in

order to be readily available to both children and adults suffering from mental illnesses. Lund (2018:1) is of the opinion that addressing mental health issues for Africans will not only aid in reducing socio-economic challenges but also reduce human rights being infringed upon due to a lack of mental health care services for people, suffering from mental disorders.

Thus, as mentioned, the aim of this study is to explore the strengths and weaknesses of current child justice legislation and practice used to deal with child offenders with psychiatric disorders. With this, both legislative, as well as procedural recommendations can be made from a trans-disciplinary perspective, to improve services and increase the number of specialists in the child justice system.

For the best interest principle to be effectively protected, as intended by the South African Constitution (section 28), factors such as individualised assessments and treatment plans, from a holistic perspective, are required. Thus, to meet the aim and purpose and implement legislation in the manner it was intended, a trans-disciplinary approach must be taken when dealing with child offenders with psychiatric disorders. The expertise of specialists from psychological, criminological, medical, legal and social fields should be utilised in the child justice system. This will ensure that an assessment conducted on a child who enters into the justice system is case specific and that the child is dealt with from a multi-contextual, and not a single-dimensional perspective, as currently used in the South African child justice system (Child Justice Act, section 11; Geoffrey, 2016:179). Recommendations made in this regard will be explored in detail in chapter 5 of the study.

3.7 CONCLUSION

Findings from Geoffrey (2016) served as the point of departure in this study. Psychiatric disorders, such as ADHD, IDD, LD, ODD and CD, were identified as the most common psychiatric disorders to affect children in conflict with the law (Geoffrey, 2016: 121). The categorisation and diagnostic criteria used for children with neurodevelopmental and disruptive, impulse-control, and conduct disorders were explored in terms of the criteria in the DSM-5 (2013). Symptoms and characteristics of the aforementioned psychiatric disorders were outlined in the contents of this chapter. The influence of all five disorders was supported with

research from Nigeria, Botswana, Namibia, and South Africa, which highlighted the influence of psychiatric disorders on children's pre-disposition to become criminally involved, and the prevalence thereof.

In addition, this chapter focused on the concept and causes of psychiatric disorders, criminality of children and relevant factors as to why the child justice system should be concerned with the influence of psychiatric disorders on child offenders. The next chapter will provide an analysis of international treaties and domestic legislation pertinent to child offenders with psychiatric disorders.

CHAPTER 4

AN ANALYSIS OF INTERNATIONAL TREATIES AND DOMESTIC LEGISLATION PERTINENT TO CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS IN SELECTED AFRICAN COUNTRIES

4.1 INTRODUCTION

International treaties are in place which guides the global milieu for the treatment of child offenders. Each sovereign nation, however, enacts its own domestic legislation on child justice as a branch of public law. The majority of the legislative provision used to deal with children in conflict with the law in the African countries of comparison aims to uphold the best interest standard.

Upholding rights, and meeting the best interest of children, including children in conflict with the law, is of importance. Children's behaviour and predisposition to criminal activity are dependent on how the child is treated and raised. With that said, the protection, correct practice, and maintenance of children's rights, including the rights of children with psychiatric disorders who come into conflict with the law, is imperative to ensure that the physical, emotional and developmental needs of this vulnerable group are attended to correctly.

This chapter will focus on international and domestic human rights instruments applicable to child offenders with psychiatric disorders to wit the UNCRC (1990), the UN Rule for the Protection of Juveniles Deprived of their Liberty (1990), the Beijing Rules (1985), the Riyadh Guidelines (1990), the ACRWC (1990) and the UNCRPD (2007).

In addition to the influence of the international treaties, the ACRWC (1990) greatly informed the development of African child justice legislation and will, therefore, be discussed in detail. The focus will be placed on the legislative framework used to deal with child offenders. Here, child justice and mental health legislation used in Nigeria, Botswana, Namibia, and South Africa will be explored. Under the legislative framework of Botswana, the Botswana Constitution (2006) the Children's Act (2009) the Botswana Penal Code (1964) and the Botswana Mental Disorders Act (1961) will

be explored. Regarding Nigeria, the Nigerian Constitution (1960), the Children's Rights Act (2005), Children and Young Persons' law of Nigeria (1990), the Nigerian Criminal Code (1916), the Nigerian Penal Code (1960) and the Lunacy Act (1958) will be discussed. Regarding Namibia, the Namibian Constitution (1998), the Child Care and Protection Act (2015), the Criminal Procedure Act of Namibia (2004) and the Mental Health Act of Namibia will be explored. In South Africa, the South African Constitution, Children's Act (2005), Child Justice Act, Criminal Procedure Act and the Mental Health Care Act will be discussed, as they pertain to children in conflict with the law who suffer from psychiatric disorders.

Existing legislation employed in the African countries under consideration deal with child offenders with psychiatric disorders under the same legislative banner used for adult offenders with a mental impairment or psychiatric disorder. The topic under research in this study, however, is explored cognisant of the fact that research has impressed the importance of having specific and separate legislation that deals with child offenders with psychiatric disorders (Geoffrey, 2016:174; Human, 2015:101-103). This, however, is not the case in the countries under examination.

Thus, the aim of this chapter is to conduct a comparative analysis, specifically pertaining to procedural and legislative mechanisms, in the African countries under discussion, used to deal with child offenders with psychiatric disorders. Here, questions will be asked about whether and to what extent the rights and best interest of the child offender with a psychiatric disorder are upheld.

4.2 INTERNATIONAL HUMAN RIGHTS TREATIES

4.2.1 United Nations Convention on the Rights of the Child (UNCRC) (1990)

The UN Convention on the Rights of the Child (1990)¹ is grounded in the best interest of the child. Countries which are signatories to this international treaty are responsible for, and obliged to, endorse legislation within its context and apply it to domestic legislation. South Africa ratified the UNCRC (1990) in 1995. The Convention (UNCRC, 1990) provides a detailed framework pertaining to the rights of children, as well as children in conflict with the law. The four guiding legislative principles set out in the Convention to assist state parties include, the child's best

¹ Hereafter referred to as the UNCRC, 1990.

interest in all decisions, the right to non-discrimination, the right to life, survival, and development and the importance of seeking and respecting the views of the child (UNCRC, 1990, article 37 (c)).

Articles 37 and 40 (UNCRC, 1990) focus specifically on the rights of children in conflict with the law and are therefore of significance to this study. Provisions made under article 40 of the UNCRC (1990) are aligned and echoed in South African domestic legislation pertaining to the rights of children in conflict with the law.²

According to article 37(a-b) (UNCRC, 1990), the arrest and imprisonment of a child offender shall be used as a measure of last resort for the shortest period and no child shall be exposed to torture, cruel, inhumane, or degrading treatment. Article 37(c) (UNCRC, 1990) stipulates that every child deprived of his liberty ought to be held separately from adults and if it is considered in the child's best interest, the right to maintain contact with his/her family will be granted. Article 37(c) of the UNCRC (1990) is significant to this study since the focus is drawn to imprisonment as a last resort and the prevention of inhumane treatment for children in conflict with the law. Factors under this article (UNCRC, 1990, article 37 (c)), such as protection from torture, degrading treatment, and imprisonment as a last resort, tie in with the intention to meet the best interest standard pertaining to the methods used to deal with children in conflict with the law. If the contents of these articles are implemented and practised as intended, children in conflict with the law will be dealt with in a fair and just manner. The implementation and application of the articles outlined in international treaties, such as the UNCRC (1990), will be explored in the context of its signatory countries, namely Namibia, Botswana, Nigeria, and South Africa later this in this chapter.³

All parties that are a signatory to the UNCRC (1990) are responsible for establishing a legislative framework pertaining to the minimum age of criminal capacity (UNCRC, 1990, article 40(3a)). The contents of article 40 (ss2(b)(i)) (UNCRC, 1990) emphasises the right to innocence, until proven guilty, for every child accused of committing a crime. Children in conflict with the law have the right to receive prompt

² This will be discussed later in this chapter.
³ Discussed later in this chapter.

information pertaining to the charges brought against them, and the right to a legal guardian/assistant in the preparation of a defence (UNCRC, 1990, article 40 (2(ii))).

Article 40(3b) (UNCRC, 1990), acknowledges and identifies the services that ought to be granted to children in conflict with the law, in order to address their special needs. These include education, counselling, probation, options for diversion and vocational training programmes. Article 40(3b) (UNCRC, 1990) is of significance to this study, since it draws focus to the diverse services that ought to be available, in order to address and treat this vulnerable group of children.

Under article 23 of the UNCRC (1990), the rights of children with mental disabilities are addressed. These mental health care rights are also applicable to children in conflict with the law and are therefore significant to this study. According to article 23(1) and (3) of the UNCRC (1990), children suffering from mental disabilities have the right to receive treatment and have access to services that promote dignity, and self-reliance; which is conducive to the development and special mental health needs of the child. The rights of people with disabilities are also addressed in the UNCRPD (2007).⁴ While the UNCRPD (2007) does not highlight any new human rights, it compliments and elucidates the legal duties and procedures stipulated under the UNCRC (1990) (Boezaart & Skelton, 2011:7). The mental health care rights of children outlined under the UNCRC (1990, article 23) are of importance since all countries that ratified this treaty ought to provide these specialised services in order to promote dignity and meet the specific mental healthcare needs of each child.

In addition, article 23(4) (UNCRC, 1990) outlines that all parties ratified to this treaty are obliged to improve services for children with mental disabilities, as well as develop capacity and skills to effectively deal with children who suffer from mental disabilities. Provisions made here, under article 23 of the UNCRC (1990), are echoed in South African domestic legislation.⁵

This chapter aims to explore human rights instruments and domestic legislation used to deal with child offenders with psychiatric disorders. Chapter 3 explored pertinent psychiatric disorders and the influence of psychiatric disorder on the child's

⁴ The UNCRPD (2007) is discussed later in this chapter.

⁵ As discussed later in this chapter.

predisposition to criminality. With cognisance of the effects that psychiatric disorders have on children, and based on the contents of international human rights instruments, namely the UNCRC (1990), countries which ratified this international treaty are obliged to align legislation, as well as methods of practice to meet the best interest standard for child offenders with psychiatric disorders. Although these rights are documented under the UNCRC (1990) and also stipulated under domestic legislation; the implementation and practice thereof in South Africa, Botswana, Nigeria and Namibia is questioned in respect of meeting the best interest of a child offender suffering from a psychiatric disorder.

4.2.2 The United Nations Guidelines for the Prevention of Juvenile Delinquency (1990) ('Riyadh Guidelines')

The primary focus of the 'Riyadh Guidelines (1990)', pertains to the rights and welfare of young people. Encompassed in the Riyadh Guidelines (1990) are strategies to address the needs, motives, opportunities, and other related factors, on the causation and prevention of criminal behaviour in children and adolescents.

Fundamental principles, which are addressed in sections 1 to 4 of the Riyadh Guidelines (1990), promote the active participation of children and adolescents in society, to enhance positive early childhood development. Similar to the objectives echoed in the South African Child Justice Act, sections 5 and 6 of the fundamental principles (Riyadh Guidelines, 1990) encourage a restorative justice system for children who exhibit defiant behaviour and/or who are accused of minor criminal offences, instead of criminalisation and labelling.

This approach provides a supportive system of individualised educational and therapeutic programmes which promote the development and well-being of each young person (Riyadh Guidelines, 1990, section 5-6).

It is of significance to this study to note that a restorative justice systems approach, which is case-specific to each child's needs, on a holistic and multi-dimensional level, is deemed effective, not only for child offenders with psychiatric disorders, but for all children who come into conflict with the law, since this approach focuses on individualisation and the factors which caused the child to come into conflict with the law.

The restorative approach, established by the Riyadh Guidelines (1990), for crime control and prevention, does not offer a quick or easy solution to juvenile delinquency but rather a long-standing, effective means to address the causative factors that predispose young people to criminal behaviour (Skelton & Tshehla, 2008:18).

4.2.3 The UN Standard Minimum Rules for the Administration of Juvenile Justice (1985) (Beijing Rules)

Like the Riyadh guidelines (1990), the Beijing Rules (1985), also referred to as the Beijing Rules of 1985 is grounded on the rights of children in conflict with the law and furthermore the prevention of juvenile delinquency, from an international perspective.

Section 5 of the Beijing Rules (1985) echoes the guiding principles of the Child Justice Act (section 3) which focuses on the well-being of the child and reinforces that the consequences arising from a criminal offence, should be in proportion to the circumstances of the offence, the child as well as society.

The consideration of circumstantial factors, in dealing with child offenders, and specifically child offenders suffering from psychiatric disorders is of significance to this study since this group of children have an increased risk of coming into conflict with the law.⁶ By adhering to the international conventions and domestic legislation, and taking into consideration circumstantial factors, namely biological, psychological, social and environmental factors, which predisposed a child to criminal behaviour, the well-being and best interest of a child will be upheld in the justice system.⁷ With this, the consequence which arises from the criminal behaviour will be in proportion to the offence and consideration will be granted to the influence of the psychiatric disorder on the child's behaviour, levels of aggression, self-control, cognitive and conative processing.

⁶ Refer to chapters 2 and 3 for detailed discussion on the prevalence and causative factors for child offenders with psychiatric disorders.

⁷ Refer to chapter 2, on causative factors influencing the development of psychiatric disorders and criminal behaviour; chapter 4 on best interest standard and chapter 5 on research findings pertaining to the causative factors and factors considered necessary to meet the best interest of the child.

4.2.4 The United Nations Rule for the Protection of Juveniles Deprived of their Liberty (1990)

Children who come into conflict with the law are a vulnerable group; this vulnerability is recognised under the UN rule for the protection of Juveniles Deprived of their Liberty (1990, guideline 17). Guideline 17 aims to protect the vulnerability of juveniles from victimisation and abuse and places emphasis on upholding the rights of children in conflict with the law. This includes the right to innocence until proven guilty, detention as a last resort and for the shortest period, and access to legal services, as echoed under article 40 of the UNCRC (1990). Similar to that which is resonated in the UNCRC (1990, article 37 a-b) and the Beijing Rules (1985, rule 17); the UN rules for the protection of Juveniles Deprived of their Liberty (1990) advocate against punishment, degrading, cruel and inhumane treatment of this group of children.

In addition to the protective measures mentioned in the UN rule for the protection of Juveniles Deprived of their Liberty (1990), guideline 28 outlines that the mental, physical, and moral integrity of the child/adolescent should be protected, in the case of detention. Guideline 38 (UN rule for the protection of Juveniles Deprived of their Liberty, 1990) makes further mention that child offenders suffering from cognitive and learning difficulties have the right to receive specialised care and educational facilities, which promote the child's personal needs and development. Both guidelines 28 and 38 (UN rule for the protection of Juveniles Deprived of their Liberty, 1990) are of significance to this study since the emphasis is drawn to the influence of mental health issues and the need for specialised care for this vulnerable group.

4.2.5 African Charter on the Rights and Welfare of the child (1990) (ACRWC)

The UNCRC (1990) informs domestic African child justice legislation. The ACRWC (1990) is a human rights instrument also informed by the UNCRC (1990). This African human rights instrument adopted and applied the four core legislative pillars of the UNCRC (1990) discussed above. The ACRWC (1990) is of significance to this study since it acts as the cornerstone for South African child justice legislation, namely the Children's Act and the Child Justice Act as discussed hereunder.

Since this study focuses on the rights and best interest of child offenders with psychiatric disorders, the preamble of the ACRWC (1990) is of significance. Here, an emphasis is placed on the need to recognise individual physical and mental development, and the care required pertaining to the mental, moral, physical health and legal protection of the child (ACRWC, 1990, preamble). Similarly, section 2 of the Children's Act (2005) and section 11 of the Child Justice Act, focus on factors pertaining to the best interest of the child. The influence and consideration of these factors are of importance since they underpin the standards used when determining if the best interests of the child are met.

Similar to article 2 of the UNCRC (1990), the Beijing Rules (1985, rule 17) and the UN Rule for the Protection of Juveniles Deprived of their Liberty (1990c); article 3(2) and 5(3) of the ACRWC (1990) outlines the right to non-discrimination, protection of life and development and protection from the death penalty for criminal offences. This provides a protective legislative mantle for children, against any form of discrimination and against the death penalty. With this, child offenders, found guilty of a criminal offence will be protected under provisions of domestic legislation and not be subjected to the death penalty, regardless of the seriousness of the criminal act.

Article 13(1) and 13(2) of the ACRWC (1990) are of particular significance to this study since the rights of children who are mentally and/or physically disabled are emphasised. Although children suffering from psychiatric disorders are not considered mentally disabled, impairments in the pre-frontal cortex of the brain, cognitive and conative, as well as intellectual development are a few of the shared difficulties and disabilities experienced by this group of children (Austin et al, 2014:513-514). These deficits found in children who are mentally impaired; and the influence this has on the child's behaviour is supported in research and underpinned in criminological theory, and is therefore significant to this study (Moffit, 1993; Agnew, 2001:319; Fishbein, 1990; Damasio & Bechara, 2005; DSM-5, 2013: 33, 59,60,66-67, 462,470-473).⁸

Chapter 3 of this study provided clarity on factors pertaining to the impairments and disabilities experienced by children suffering from psychiatric disorders. Here, the

⁸ Discussed in chapter 2 and chapter 3 of this study.

need for a multi-contextual approach, which includes a trans-disciplinary team of child justice professionals, was outlined. Against the background of the case-specific needs of child offenders with psychiatric disorders, article 12(1) and 12(2) of the ACRWC (1990) promises legislative protection for a child's physical and moral needs and obliges the state to ensure the availability of resources proper to each child's condition. Although these rights are stipulated in the ACRWC (1990), and under domestic South African law, i.e. section 7(h) of the Children's Act and section 11 and the preamble of the Child Justice Act, research proves that these rights are constantly infringed upon in African countries. This infringement is reflected in the lack of available services and service-providers for child offenders with psychiatric disorders (Lund, 2018:1; Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016:172).

The best interest principle is the focal point of this chapter. Similar to article 3 of the UNCRC (1990), article 4 of the ACRWC (1990) pertains to the best interest of the child. Here it is stipulated that the best interest of the child shall be of primary concern in all actions taken relating to the child. Further to this, article 4 (ACRWC, 1990) outlines that in administrative and judicial proceedings, a child who is capable of communicating his views shall be given the opportunity to voice these views, either by himself or via a relevant representative. It is then the duty of the relevant authority to take these views into consideration when dealing with a child who has come into conflict with the law. It is of significance to note that, although this legislative stipulation is clearly outlined, this practice does not always occur in the child justice system (Zetterman, 2010:4).

To ensure that children are dealt with from a case-specific perspective; taking into consideration the views and experiences of the child, child justice practitioners should adopt a holistic approach, which incorporates legislative factors as well as specific factors found to affect the child. Aspects of article 14 (ACRWC, 1990) deal with the health and health-service rights of the child. Article 14(1) (ACRWC, 1990) obliges state parties to supply the best attainable physical and mental health

services for children in need of such care. Mental health care services are scarce in African countries as previously demonstrated.⁹

Article 14(2d) (ACRWC, 1990) makes a clear distinction on the rights of the child exposed to child malnutrition. Research indicated that, due to socio-economic difficulties, a lack of mental health services and exposure to child malnutrition; children in African countries are at an increased risk of coming into conflict with the law (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550). Although the intention of human rights instruments, such as the ACRWC (1990), is to ensure that the best interest of the child is upheld, findings from this study indicates that a lack of commitment and legislative implementation by the signatory countries render children, specifically child offenders with psychiatric disorders, with limited or no means of rehabilitation, to break the cycle of anti-social and criminal behaviour.

Similar to article 39 of the UNCRC (1990), article 16 (ACRWC, 1990) focuses on the child's rights to protection against torture and abuse. Here, specific legislation is outlined to protect the child from inhumane or degrading treatment. This includes physical and/or mental abuse, neglect, and maltreatment.

Aspects found under article 17 (ACRWC, 1990) deal with the administration of juvenile justice for children. According to article 17(1) (ACRWC, 1990), every child accused of committing a criminal offence, has the right to special treatment conducive to the child's dignity which reinforces respect for the child's fundamental rights and freedom. Article 17(2) (ACRWC, 1990) clearly specifies that no child shall be detained, imprisoned, or otherwise detained and/or subjected to torture, degrading or inhumane treatment.

Under article 17(2)(a-d) (ACRWC, 1990), a clear distinction is made on the rights of a child found to be in conflict with the law. Here child offenders have the right to the presumption of innocence until proven guilty, to legal assistance in the justice system, and to a prompt/speedy trial (ACRWC, 1990). In addition, article 17(3) of the ACRWC (1990) outlines that the aim of treatment for every child, who comes into

⁹ Refer to chapter 3 for a detailed discussion on the lack of services available to child offenders with psychiatric disorders.

conflict with the law, is that he should be reformed, reintegrated, and rehabilitated back into society. For African countries to meet the standards outlined under article 17(3) (ACRWC, 1990), and to provide effective treatment and for the child to be receptive to such treatment, child justice practitioners need to adopt a multi-contextual approach to dealing with this group of children.

It must be acknowledged that, although the ACRWC (1990) is a well-developed human rights instrument, studies reflect omissions which fail to uphold the best interest of the child (Gose, 2002:68-69). These omissions have been reflected in findings from Gose (2002: 68-69), and include a lack of provision for the protection of the child's liberty which fails to establish that the arrest, detention or imprisonment shall be used only as a last resort and for the shortest appropriate period of time as stipulated by articles 37(b) and article 37(a) of the UNCRC (1990), respectively. The South African Constitution, in section 28 (1)(g), makes provision for the protection of children deprived of their liberty, as found in the UNCRC (1990, article 37).¹⁰

As outlined previously, the best interest of child offenders with psychiatric disorders is the focal point of this thesis. Article 20(a) of the ACRWC (1990) speaks to the best interest standard. Article 20(a) stipulates that it is the parent's duty to ensure that the child receives basic care which is always in his best interest. This is of importance since as outlined earlier, certain prenatal factors were found to be the cause of psychiatric disorders and criminal behaviour in children. This indicates that factors inflicted upon the child before birth, pre-dispose the child to develop a disorder; which is a direct violation of the child's right to protection and impedes his best interest. State parties hold the responsibility to assist parents with basic child rearing facilities and to develop institutions for child-care.

In concluding this discussion, attention is drawn to the different terms used in regard to the best interest standard. Although the best interest principle of the child is specified in the UNCRC (1990) as well as the ACRWC (1990), factors included under article 4 of the ACRWC (1990) are omitted from article 3 of the UNCRC (1990) as follows:

¹⁰ Explored later in this chapter.

“In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration” (UNCRC, 1990, article 3)

“...In all actions concerning the child undertaken by any person or authority, the best interests of the child shall be the primary consideration.

1. In all judicial or administrative proceedings affecting a child who is capable of communicating his/her own views, an opportunity shall be provided for the views of the child to be heard either directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate law.” (ACRWC, 1990, article 4).

The demonstrated omission creates the ideology that the ACRWC (1990, article 4) provides a more detailed and thorough definition of the best interest standard, in comparison to that stipulated in the UNCRC (1990). Factors pertaining to the rights of children, as well as children in conflict with the law are similar in the ACRWC (1990, article 17) and the UNCRC (1990, article 40). Under these human rights articles, the child's rights to protection as well as due process are impartiality documented.

It is significant to note that the ACRWC (1990) does not make special legislative provision for mental health care rights for child offenders with psychiatric disorders. For the purpose of this study, the UNCRPD (2007) will provide content insofar as international mental health care rights.

4.2.6 The UN Convention on the Rights of Persons with Mental Disabilities (UNCRPD)

In addition to the human rights instruments mentioned above, the UNCRPD (2007) recognises the rights and needs of persons with mental disabilities (UNCRPD, 2007). This convention addresses the general rights of persons with mental disabilities; and is of significance to this study since areas in the UNCRPD (2007) outline and clarify state obligations pertaining to children with mental disorders.

Article 1 (UNCRC, 2007) defines mental disabilities as: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. Based on this definition, children suffering from neurodevelopmental and disruptive, impulse-control, and conduct disorders¹¹ are within the category of disabled children and should, therefore, enjoy the protection of rights and services available under international law under the South African government’s domestic obligations and duties.

The preamble, article 3 and article 7 of the UNCRC (2007) place emphasis on the best interest of the child. This is demonstrated under the stipulation that, in all decisions taken consideration ought to be granted to influential factors, namely the age, maturity, cognitive development and all environmental circumstances that could affect a child who suffers from a mental disorder. In the context of this study, it is of significance to recognise factors which are influential for the development of mental disorders, since similar factors have been identified as also contributing to the criminal behaviour of children (Neuman, 2015:1; World Health Organisation, 2015:1; Pelser, 2008:4; Cortina et al, 2012:276-281; Trollip, 2014:1; Ntsabo, 2018:1; Geoffrey, 2016:111,16-167; Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550).¹²

Even though the UNCRC (2007) does not specifically pertain to the rights of children in conflict with the law, as mentioned, this international human rights instrument, informed by the UNCRC (1990), dictates the responsibilities of the state and should be applied to the rights of this vulnerable group of children. Domestic legislation on the rights of persons with mental health disorders is outlined in the South African Mental Health Care Act. The domestic rights applicable to child offenders with psychiatric disorders will be discussed later in this chapter.

It is important now to turn from the international field towards domestic legislation about child offenders and child offenders with psychiatric disorders specifically. Hereunder the researcher considers the South African domestic legislative situation

¹¹ Refer to chapter 3 for a detailed discussion on definitions, symptoms, and characteristics of neurodevelopmental and disruptive, impulse-control, and conduct disorders.
¹² See chapter 2 in this regard.

and then compares same to Nigeria, Namibia, and Botswana. The comparative aspect of this analysis is essential to prove the factors relevant to the best interest standard and to then highlight the degree to which they have been accommodated by legislation or not, as the case may be.

4.3 CONSTITUTIONAL LAW AND DOMESTIC LEGISLATION PERTAINING TO CHILD OFFENDERS: AN AFRICAN PERSPECTIVE

4.3.1 South Africa

South African domestic child justice legislation has been progressive in its development. At present, children who suffer from psychiatric disorders, who come into conflict with the law are dealt with in terms of the South African Constitution (1996), the Children's Act (2005), the Child Justice Act (2008) and the Criminal Procedure Act (1977). In this section, constitutional and legislative provisions that specifically deal with child offenders with psychiatric disorders will be explored.

4.3.1.1 The Constitution of the Republic of South Africa, 1996

The South African Constitution proffers, under the founding provisions, that South Africa is grounded in the values of human dignity, equality, and the right to freedom. Although the contents of the Constitution pertain to the rights of South Africans in general, and not specifically to children or child offenders, this section will outline particular sections which apply to the focus group of this study.

In line with article 40(2)(b) (i) of the UNCRC, section 35(3)(h) of the South African Constitution provides a protective mantle, in the form of the presumption of innocence, until proven guilty, for persons accused of a criminal offence. Under section 28(g) it is stipulated that, when a child is found to be in conflict with the law, detention should only be used as a measure of last resort and for the shortest period of time. This legislative stipulation echoes article 37(a) – (c) of the UNCRC (1990) as outlined above and is of importance since it places emphasis on upholding the best interest of a child in conflict with the law.

Section 28 of the Constitution provides a protective mantle for the best interests of children. In section 28(2) it is stipulated that the child's best interest is of paramount

importance in all matters concerning the child. Although section 28(2) makes a clear provision pertaining to the best interest of the child, it does not provide a specific framework for determining if the best interest standard has been upheld. It further does not provide a set of factors considered essential to the best interest standard or its interpretation. The risk involved with this lack of specific legislative guidance (with the exception of the general guidance provided in the Child Justice and Children's Act which simply aims to give flesh to the constitutional best interest stipulation), pertaining to assessment of best interests, indicated from the findings in this study, is that child justice practitioners lack consistency in the methods used; thus, the best interest of each child will be assessed against a different framework in the evaluation of children with a psychiatric disorder.. Although the best interest of a child is an individualised standard it is disconcerting that there are no real guidelines (outside of academic writing and judicial interpretation) that can be used to determine the best interest of a child offender with a psychiatric disorder in South Africa.

Section 28(1)-(c) of the Constitution is aligned with article 14 of the ACRWC (1990) which outlines the rights to basic health care and social services. In addition, the right to protection against maltreatment, neglect, and/or abuse is further stipulated under section 28(d). Although the Constitution makes provision, with the intention of protecting South African children against exposure to child maltreatment and neglect; research identifies that this right is constantly infringed upon and resultantly some children are pre-disposed to psychiatric disorders and criminal behaviour (Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016:111).

While the Constitution stipulates human rights protection of children and guarantees the protection of their best interests, it falls to legislation to implement and develop this human rights protection. With this in mind, the researcher now turns to consider South African legislation pertinent to the protection of the best interest standard for child offenders generally and for child offenders with psychiatric disorders specifically.

4.3.1.2 The Children's Act 38 of 2005

The Children's Act emphasises the best interest of the child standard. Section 9 of the Act stipulates: "In all matters concerning the care, protection and well-being of a child the child's best interest is of paramount importance".

In addition to this, section 7 of the Children's Act makes special provision for factors to take into consideration to meet the best interest standard. From those listed in section 7 the following factors are relevant to this study: the capacity of parents/relevant guardian, nature and personal relationship between parent and child, age, maturity, stage of development, physical, intellectual, emotional, social and cultural development, any disabilities, the need for the stability of family and environment and non-exposure to maltreatment, abuse, violence. These factors must be taken into consideration and applied to conduct an analysis of the best interest standard for child offenders with psychiatric disorders.

Section 6(2) (f) and 11 of the Children's Act recognises and draws attention to children with disabilities and their special needs. In this regard: "All proceedings, actions or decisions in a matter concerning a child must recognise a child's disability and create an enabling environment to respond to the special needs that the child has". In addition, section 11 makes special provision for care offered to children with disabilities. Here, legislation outlines that children with disabilities enjoy the right to special care and support services, which uphold their dignity. Factors pertaining to special care and services that should be available to child offenders with psychiatric disorders are of significance to this study. Chapter 3 highlighted literature which acknowledged the lack of services and resources available to this group of children in South Africa (Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016: 172). Against this background, it can be concluded that, despite South Africa's ratification of international human rights instruments, such as the UNCRC (1990), her mental health services are still limited. This not only fails to meet the best interests of this group of children but also infringes upon their basic rights.

As highlighted above, the preamble of the UNCRPD (2007) and article 13 of the ACRWC (1990), dictate a similar provision pertaining to the rights and well-being of children with disabilities. These stipulations (Children's Act, section 6; UNCRPD, 2007, preamble; ACRWC, 1990, article 13) are of significance to this study, since they emphasise the constitutional rights of protection, recognise the vulnerability of children with disabilities, such as those with psychiatric disorders, and the importance of addressing their special needs.

According to section 7(g-j) (Children's Act), when dealing with children, factors such as age, maturity, stage of development, intellectual, emotional, and social development and the impact of a disability or chronic illness, are paramount to the best interest of the child. These factors are pertinent to the study since they identify and acknowledge the importance of taking a holistic approach when dealing with children, including child offenders.

Section 150 (Children's Act) defines a child in need of care and protection as one who is in a state of physical or mental neglect and who exhibits behaviour that the parent and/or caregiver is unable to control. The recognition of disruptive, uncontrollable behaviour as a risk factor, in the identification of a child in need of care and protection, is of relevance since such behaviour is symptomatic of children with psychiatric disorders, such as ODD and CD.¹³ Children, who exhibit uncontrollable behaviour due to the impact of psychiatric disorder, are disabled by the impact of the disorder and are therefore in need of care and protection since they have an increased risk of coming into conflict with the law (Breen, 2011:6-7).

The Children's Act provides legislative guidelines pertaining to South African children in general. For this study, legislation which specifically pertains to child offenders is of significance. Legislation in this regard is documented under the Child Justice Act, discussed below.

4.3.1.3 Child Justice Act 75 of 2008

South African child offenders, suffering from psychiatric disorders, are dealt with in terms of the Child Justice Act and Criminal Procedure Act. Like the preamble of the ACRWC (1990), the Child Justice Act (preamble) also provides that children in conflict with the law are entitled to enjoy the right to mental, moral, and physical health and legal protection.

Pertinent to this study is the Bill passed in October 2018, containing amendments to the Child Justice Act (DOJ&CD, Child Justice Amendment Bill, 2018). According to the summary (DOJ&CD, Child Justice Amendment Bill, 2018:3):

¹³ Discussed in chapter 3.

“...the purpose of the bill is to amend the Child Justice Act, 2008 (Act No. 75 of 2008) so as to amend a definition; to further regulate the minimum age of criminal capacity; to further regulate the provisions relating to the decision to prosecute a child who is 12 years or older but under the age of 14 years; to further regulate the proof of criminal capacity; to further regulate the assessment report by the probation officer; to further regulate the factors to be considered by a prosecutor when diverting a matter before a preliminary inquiry; to further regulate the factors to be considered by an inquiry magistrate when diverting a matter at a preliminary inquiry; to further regulate the orders that may be made at the preliminary inquiry; to amend wording in order to facilitate the interpretation of a phrase; and to further regulate the factors to be considered by a judicial officer when diverting a matter in a child justice court; and to provide for matters connected therewith”.

These amendments are intended to reduce financial burdens which arise from criminal capacity assessments and evaluations. In cognisance of the overall purpose of the amendments, only factors which are of significance to this study will be explored.

Section 1 of the Child Justice Act defines a child as one who is 18 years of age or younger. According to section 4(2) in certain circumstances, a child may also be defined as persons older than 18, but younger than 21 years of age. The Child Justice Act (section 7) acknowledges the rights of children within various age categories, and functions on a system of minimum age and rebuttable age of criminal capacity.

The age of the child is of relevance since this will dictate the procedure and legislative framework under which the child offender will be dealt, as stipulated the Child Justice Act. The minimum age of criminal capacity has been amended from 10 to 12 years of age (Child Justice Amendment Bill, 2018:2). According to section 7 of the Child Justice Act, a child younger than 12 years of age, at the time of the alleged offence, is irrefutably presumed to lack criminal capacity (referred to as ‘*doli incapax*’) and therefore cannot be prosecuted.

A child, between 12 and 14 years of age, is rebuttably presumed to lack criminal capacity (*doli incapax*); unless the state can prove beyond a reasonable doubt that the child in question possessed the capacity to appreciate the wrongfulness of his actions and the ability to act in accordance with that understanding, at the time of the alleged offence (Child Justice Amendment Bill, 2018:2, section 7(2)). As discussed previously, criminal capacity is determined by the ability to distinguish between right and wrong (cognitive ability) and the ability to act in accordance with that knowledge (conative ability) (Child Justice Act, section 11).¹⁴ The Child Justice Act provides a protective mantle for children in conflict with the law and prevents automatic prosecution (Gallinetti, 2009:18). Similar to article 17(2) (i) of the ACRWC (1990), section 7(2) of the Child Justice Act dictates that children who find themselves in conflict with the law are presumed innocent until proven guilty.

Prior to the amendments discussed above, there was a great deal of advocacy towards increasing the minimum age of criminal capacity. The primary objective of the Child Justice Amendment Bill (2018:10) is to increase the age of criminal capacity, to remove requirements to prove criminal capacity for diversion and to provide consequential amendments. Amendments made to sections 7 and 11 increased the age of criminal capacity from 10 to 12 years. The researcher avers that this is an improvement but is still not in line with international standards and conventions, namely the UNCRC (1990), which suggests a minimum age of criminal capacity of 14 years. According to amendments made to section 8, the provisions relating to the minimum age of criminal capacity must be reviewed in 5 years.

A child, between 14 and 18 years of age, at the time of the alleged offence, is presumed to have full criminal capacity (*doli capax*) and can, therefore, be held liable for his misconduct (Child Justice Act, section 5).

Sections 7(2), 28(1), 48(3) and 53(3) of the Child Justice Act, which will be discussed below, are of importance to the focus of this study since these sections are aligned to and echo article 40 of the UNCRC (1990), pertaining to criminal capacity, legal representation and the provision of services for children in conflict with the law.

¹⁴ Refer to chapter 3 on the influence of psychiatric disorders and criminal capacity.

A further change noted (Child Justice Amendment Bill, 2018, section 10(1)), which is of significance to this study pertains to the decision-making process by a prosecutor, when determining whether to prosecute child offender, between 12 and 14 years of age. The current use of 'cognitive ability' will be removed since it is considered that prosecutors are not adequately equipped to consider the cognitive ability of the child. This is of significance to this study since, although not within the scope and expertise of a prosecutor, a prosecutor dealing with child offenders ought to have basic knowledge pertaining to the cognitive and conative functioning of children, since these are factors used when determining criminal capacity.¹⁵ The question which then arises is, how does a prosecutor, who is the decision-maker, determine if the prosecution is necessary without considering the child's cognitive abilities which affect all other factors of the child's development and behaviour?

Section 11 of the Child Justice Act deals with child offenders within the rebuttable age of criminal capacity, namely 12 to 14 years. It must be reiterated that children within this age group are considered innocent unless proven otherwise. Here, should the criminal capacity of such a child be questioned, the state is obliged to prove that he had the ability, at the time of the offence to understand the wrongfulness of his actions and to act in accordance with that appreciation.

Section 34 of the Child Justice Act highlights that every child alleged to have committed an offence ought to be assessed by a probation officer. Pertinent to this study, one of the functions of the assessment conducted by the probation officer is to establish whether the child is one in need of care and protection. Section 35 of the Child Justice Act and section 150 of the Children's Act (discussed above) identify a child in need of care and protection as one in a state of mental or physical neglect who exhibits uncontrollable and defiant behaviour. This type of behaviour is similarly portrayed by children with neurodevelopmental and disruptive, impulse-control and conduct disorders (DSM-5, 2013:57, 63, 466-474). In addition to the functions of the assessment already mentioned, probation officers hold the responsibility of providing an opinion regarding the criminal capacity of the child offender (Child Justice Act, section 34). According to the Child Justice Amendment Bill (2018), section 35(g) and section 40(1)(f) will be removed, which pertain to probation officers providing an

¹⁵ Refer to chapter 3, pertaining to the determination of criminal capacity; also refer to chapter 5 for a discussion of findings from participants on the adequacy of child justice practitioners.

opinion on whether an expert witness is required, since it is reasoned that probation officers are inadequately skilled to provide an opinion on matters relating to the criminal capacity of a child (Child Justice Amendment Bill, 2018:8-10).

Chapter 3 of this study provided a detailed discussion on the categorisation, symptoms, and characteristics of ADHD, ODD, CD, LD and IDD.¹⁶ The severity of the disorder, pertaining to the child's predisposition to criminal behaviour was also outlined there. Of significance to this study, is the correlation between the severity of the mentioned psychiatric disorders and the severity of criminal offences. Research identifies a correlation between the severity of particular neurodevelopmental and disruptive, impulse-control, and conduct disorders, and the schedule of offence committed (Lundström, Forsman, Larsson, Kerekes, Serlachius, Långström, Lichtenstein, 2014:1; Alley & Cooke, 2016: 4; Selinus, Molerp, Lichtenstein, Larson, Lundstrom, Anckarsater & Gumpert, 2015; Mordre, Groholt, Kjelsberg, Sandstad & Myhre, 2011). Before delving into the correlation between the severity of psychiatric disorder and schedule of offence, it is important to note that, under section 6 of the Child Justice Act, criminal activity is determined by severity according to the following schedules:

- Schedule 1 offences are less serious criminal offences. These include, but are not limited to, theft, receiving stolen property, common assault which did not inflict severe bodily harm, blasphemy, trespassing, and public indecency.
- Schedule 2 offences are more serious offences. These include but are not limited to, assault where serious bodily harm was caused, malicious damage to property, arson, abduction, public violence, and culpable homicide.
- Schedule 3 offences are considered the most serious criminal offences, which include but are not limited to, murder, treason, rape, kidnapping, sexual assault and/or exploitation and trafficking of persons for sexual purposes.

¹⁶ Discussed in chapter 3.

With the aforesaid schedule of offences in mind, children suffering from neurodevelopmental and disruptive, impulse-control, and conduct disorders, namely, ADHD, ODD and CD, are prone to commit schedule 1, 2 and 3 criminal offences (Lundström et al 2014:2707-2716; Alley & Cooke, 2016: 4; Selinus et al, 2015; Mordre et al, 2011). However, findings from the previously mentioned studies indicate that, as the severity of symptoms of the disorder escalates, the schedule of offence becomes more serious. In this respect, child offenders suffering from less severe forms of ADHD, ODD and CD, are likely to commit schedule 1 offences, such as theft and vandalism (Lundström et al 2014:2707-2716; Alley & Cooke, 2016: 4; Selinus et al, 2015; Mordre et al, 2011). Whereas, children suffering from more severe forms of ADHD, ODD and CD, tend to commit schedule 2 and 3 offences, such as physical assault, arson, and sexual assault (Lundström et al 2014:1; Alley & Cooke, 2016: 4; Selinus et al, 2015; Mordre et al, 2011).

Although research identified the aforementioned neurodevelopmental and disruptive, impulse-control, and conduct disorders, it is the characteristics thereof, namely defiance, bad temperament, impulsivity and aggression, and their severity which are risk factors that correlate with a specific schedule of offence (Lundstrom, 2011:1). Ergo, other psychiatric disorders, which manifest similar symptoms and characteristics, namely, aggression, anti-social behaviour, and impulsivity, will also increase the risk of criminal behaviour, and the severity of the disorder will suggest the severity of the criminal act.

Thus, although research substantiates the correlation between the severity of a psychiatric disorder and the schedule of criminal offence; this does not imply that child offenders suffering from severe forms of ADHD, ODD and CD are only inclined to commit schedule 2 and schedule 3 offences, neither does this imply that child offenders suffering from less severe forms of ADHD, ODD and CD are inclined to only commit schedule 1 offences. Each child offender suffering from a psychiatric disorder is different and the inclination towards specific criminal offences will differ. The previously mentioned findings, relating to the link between the severity of the psychiatric disorder and the criminal offence should, therefore, be case-specific and considered from an individualised perspective.

Sections 47(b) and 52(a) of the Child Justice Act focus on the child's ability to acknowledge responsibility for a criminal act as a requirement for referral for diversion. Acknowledgement of responsibility renders the child a candidate for diversion. However, if the child does not acknowledge responsibility for the criminal act, the case will be referred for trial in a child justice court. Considering this study, the question arises, if a child offender with a psychiatric disorder does not fully appreciate the wrongfulness of his actions, because of the influence of the disorder on the child's cognitive abilities, how then does the child acknowledge responsibility to be diverted for treatment? Amendments were made to the Child Justice Act (Child Justice Amendment Bill, 2018, section 10(3)), pertaining to the diversion process and in this regard. "...a prosecutor may divert the matter in terms of Chapter 6 if the matter is suitable for diversion" has been added. This is of significance since, although still flawed; in terms of section 49(b), it is then the duty of the prosecuting officer to take into consideration, factors which influenced the child's behaviour from a holistic perspective, in order to provide services and meet the best interests of this vulnerable group of children.

Case in point, if legislation indicates that child justice professionals, such as prosecutors and probation officers, who are some of the major role-players in the child justice system, are inadequately skilled to determine and consider factors such as the child's cognitive abilities, or provide an opinion on if the child has criminal capacity, how then are these practitioners expected to proceed with dealing with this vulnerable group, and provide effective services which uphold the child's rights and address the individual needs of each child?¹⁷

According to the objectives of the Child Justice Amendment Bill (2018), there is a dire restraint on financial and human resources and in order for a child to be diverted, the legislation requires that the child's criminal capacity is proven; which requires lengthy assessments and procedures which are time and resource dependent. The Amendment Bill has justified this amendment by indicating that lengthy and often prolonged assessments by the justice and mental health sector do not ensure the best interests of the child.

¹⁷ Refer to chapter 5, and chapter 6, for a detailed discussion and recommendations pertaining to the child justice professionals who deal with child offenders with psychiatric disorders.

The inclusion of subsection 4a to section 11 of the Child Justice Act (Child Justice Amendment Bill, 2018, section 11(4a)) is of significance to this study, since it specifically applies to the procedure used to deal with a child offender suffering from a psychiatric disorder. The amendment (Child Justice Amendment Bill, 2018, section 11(4a)) refers to section 77(2), (3) and (4) of the Criminal Procedure Act which deals with the capacity to understand proceedings and proof thereof required when determining the criminal capacity of a child suffering from a psychiatric disorder. The application of this section is of significance since it provides legislative protection at an earlier stage of the child justice process - when determining criminal capacity - instead of the previous position where the child was referred for decision-making in terms of section 48(5) of the Child Justice Act.¹⁸

According to section 48(5) of the Child Justice Act, a preliminary inquiry may be postponed if "...the child has been referred for a decision relating to mental illness or defect in terms of section 77 or 78 of the Criminal Procedure Act". The Criminal Procedure Act and its application to child offenders with psychiatric disorders will be addressed below. Research conducted by Geoffrey (2016:172) highlighted that when a child comes into conflict with the law, there is inadequate recognition granted to the influence of the disorder, on the child's predisposition to criminal behaviour and his criminal capacity. Furthermore, it is not only important to take into consideration the impact of the disorder but to consider environmental and societal factors since these increase the risk of criminality and the child's susceptibility to developing a psychiatric disorder (Geoffrey, 2016:172). In addition to these findings, theoretical underpinnings, discussed in chapter 2, as well as the literature discussed in chapter 3, provide further support and justification for the argument on the influence of nature and nurture on a child's predisposition to psychiatric disorders and criminal behaviour.

It is against this background, that this study emphasises the importance of taking a trans-disciplinary approach to dealing with children with psychiatric disorders who conflict with the law. A trans-disciplinary child justice approach will ensure that children who enter the justice system are holistically assessed, from a multi-

¹⁸ Refer to section 11, and the inclusion of subsection 4A in the Child Justice Act; also refer to sections 77 (2), (3) and 4 of the Criminal Procedure Act.

contextual perspective, for all factors that influence the child's behaviour, criminal capacity, and risk of recidivism.

Since one of the focal areas of this chapter is the best interest standard, it is important to acknowledge that the Child Justice Act fails to prioritise the best interest standard and rather only outlines it in brief under section 80(1)(d) which pertains to procedures used to deal with child offenders. This is of concern since factors pertaining to the best interest of the child, and specifically, child offenders with psychiatric disorders should be clearly documented in the Child Justice Act as opposed to being reduced to a remark in passing. The best interest standard should be one of the focal points of the Child Justice Act, as demonstrated under the South African Constitution (section 28(2)) and the Children's Act (section 7(g)-(j)). The identification of best interest indicators, as provided by the Children's Act, should also be included in the Child Justice Act, with specific reference to the assessment of the best interest of a child in conflict with the law.

4.3.1.4 Criminal Procedure Act 51 of 1977

The Criminal Procedure Act stipulates the procedures for criminal proceedings. As found in the UNCRC (1990a, article 2(b)(i)) and since all South African legislation operates under the Constitution, the South African Criminal Procedure Act provides a protective mantle for persons accused of a criminal offence. Under this legislation all persons' accused of committing a crime fall under the presumption of innocence until the contrary is proven beyond a reasonable doubt. This legislation applies to children and adults who conflict with the law.

As outlined above, sections 77 to 79 of the Criminal Procedure Act (as referred to under the Child Justice Act, section 48), are of significance to this study since they deal with criminal capacity determinations for child offenders with mental disorders.

Amendments made to section 77 of this Act remove the term 'mental defect' and replace it with 'intellectual disability'. According to the analysis of the Criminal Procedure Bill (2017), the reasoning behind this amendment was because the earlier terminology was considered offensive and inappropriate (Criminal Procedure Bill (2017:13-14). The new terminology refers to impaired mental abilities which affect intellectual functioning, such as learning, judgement and problem solving, as well as

adaptive functioning, such as daily activities, such as communication (American Psychiatric Association, 2018:1).¹⁹ The change in terminology is still inadequate and not specific enough for all child justice practitioners. This once again creates the need for child justice practitioners to use discretion when determining issues, such as whether a child offender with ADHD or CD, fits into the category of an intellectually disabled person. Hurdles identified in areas, such as legislative terminology are further addressed in chapter 5 and 6 of the study.

Furthermore, although there have been no further legislative amendments made to the remainder of section 77, the inclusion of sections 77(2), (3) and (4) into section 11 of the Child Justice Act has been noted and discussed.

The contents of section 78 of the Criminal Procedure Act deals with cases where a psychiatric disorder is identified and the impact of the disorder, on the criminal capacity of the child, is recognised. According to section 11(3)-(4) and section 48 (5) of the Child Justice Act, if a child has a psychiatric disorder, he should be referred to a suitably qualified person for further assessment. The Act (Child Justice Act, section 11(3-4), section 48(5) & section 97(3)) identifies such persons as psychologists or psychiatrists, registered under the Health Professions Act (56 of 1974) as suitably competent to conduct criminal capacity evaluations. After the assessment, if it is found that the psychiatric disorder has had an impact on the criminal capacity of the child, the child may not be held criminally liable for his actions (Criminal Procedure Act, section 78). A child who is found to lack criminal capacity will be dealt with in terms of section 10(2)(b) of the Child Justice Act. Here, it is the duty of the probation officer to make recommendations for referral for therapeutic and developmental services.

Further to section 78(1A), section 76(6) stipulates:

“... If the court finds that the accused committed the act in question and that he or she at the time of such commission was by reason of mental illness or intellectual disability not criminally responsible for such act(a) the court shall find the accused not guilty; or (b) if the court so finds after the accused has been convicted of the offence charged but before

¹⁹ Refer chapter 3, for a detailed discussion on the definition of intellectual disability and intellectual developmental disorder.

sentence is passed, the court shall set the conviction aside and find the accused not guilty...”.

This is of significance since, in addition to the psychiatric disorders focused on in this study, section 76 of the Criminal Procedure Act makes provision for persons suffering from intellectual disabilities, and the impact thereof on the ability to appreciate the wrongfulness of actions and act in accordance therewith. Chapter 3 of this study provides a clear indication of the influence of intellectual disability on brain functioning. Children suffering from psychiatric disorders, such as IDD, experience a level of impaired intellect which influences their cognitive and conative processing, their ability to appreciate their actions and the ability to practice self-control and act in accordance with that understanding. IDD is also a prevalent psychiatric disorder found to influence child offenders.²⁰ In terms of this legislative stipulation, children suffering from ADHD, ODD and CD, could then be categorised as persons suffering from an intellectual disability.

Section 78(7) also makes provision for persons found criminally responsible, at the time of the commission of the act, but, due to the impact of mental illness, the capacity to appreciate the wrongfulness of the act and to act in accordance therewith, was diminished. In this light, the Criminal Procedure Act (section 78(7)) provides a protective mantle for child offenders suffering from psychiatric disorders, who have normal levels of intelligence and rationality, during the commission of the criminal act, yet fail to use these abilities due to the influence of a psychiatric disorder. This argument was also explored and theoretically substantiated in chapter 2.²¹ Research indicates that although child offenders suffering from psychiatric disorders may portray normal levels of intelligence, independence, thought process and rationality; due to underdevelopment or impairments found in the pre-frontal cortex, they fail to act in accordance with their cognitive ability (Damasio & Bechara, 2005:337; Agnew, 2001).

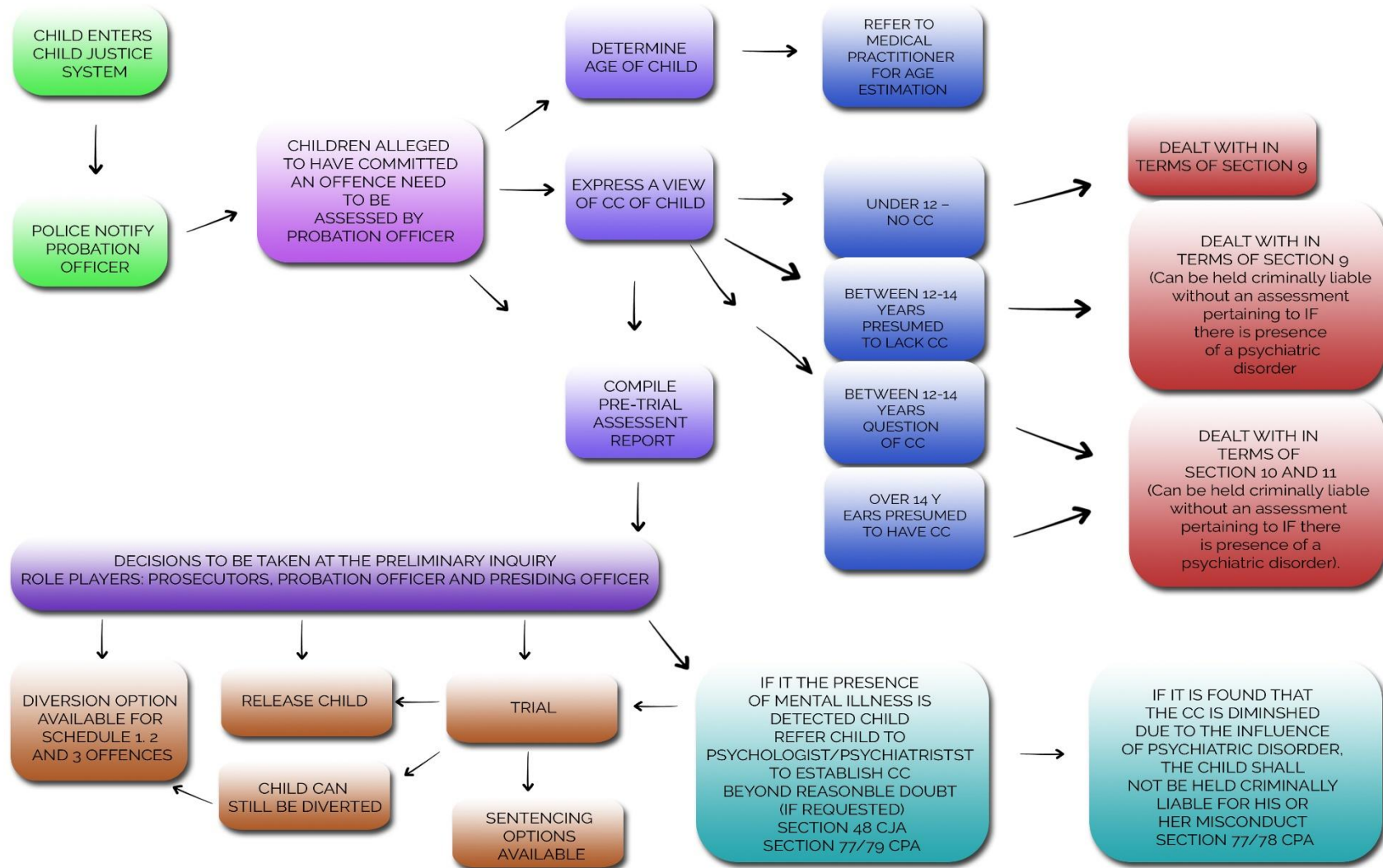
It is important to note that the Child Justice Act does not contain specific provisions pertaining to the criminal capacity of children with psychiatric disorders. Research confirms that child offenders with psychiatric disorders are a vulnerable group in

²⁰ Discussed in chapter 3.
²¹ Discussed in chapter 2.

need of care and protection and should therefore not be categorised and dealt with under the same legislation as adult offenders; but a specific provision in the Child Justice Act (McDiarmord, 2013:148; Geoffrey, 2016:177-178).

In the diagram below, the child justice procedure, as explored in the contents of this section is visually presented and incorporates aspects of the Child Justice and Criminal Procedure Act.

DIAGRAM 8: Child justice procedure applicable to a child offender with a psychiatric disorder



In addition to the Children's Act, the Child Justice Act and Criminal Procedure Act, child offenders with psychiatric disorders are also dealt with and protected by the Mental Health Care Act.

4.3.1.5 Mental Health Care Act 17 of 2002

The Mental Health Care Act (preamble) provides a protective legislative mantle for the rights of people, including children, who suffer from mental health disabilities. The preamble of the Mental Health Care Act recognises the rights of persons with mental disorders in conflict with the law. This includes the rights of child offenders with mental disorders.

As discussed in chapter 3, the Mental Health Care Act (section 1) defines a mental illness/disorder as "...a positive diagnosis of mental health-related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis". This definition plays a vital role in dictating which children with psychiatric disorders receive services and more so for children with psychiatric disorders who find themselves in conflict with the law (Boezaart & Skelton, 2011:18).

In light of section 150 of the Children's Act and article 1 of the UNCRPD (2007) children with psychiatric disorders suffer from a mental disability and are a vulnerable group in need of care and protection. Boezaart and Skelton (2011:18) opine that challenges arise when children with psychiatric disorders, such as CD, do not receive adequate care because many medical practitioners do not regard disruptive, impulse-control, and conduct disorders, such as CD, as a mental health disorder. This lack of acknowledgement should be challenged since ODD and CD, are recognised as diagnosable psychiatric disorders under the DSM-5 (2013:426, 470), which is an international diagnostic schedule for the diagnosis of mental disorders. Furthermore, the definition and identification of mental disabilities under international human rights instruments and domestic legislation imply that psychiatric disorders, such as the disruptive, impulse-control, and conduct disorders cause substantial disability and are diagnosable mental disabilities. Thus, children suffering from these disorders are a vulnerable group in need of care and protection. If the domestic legislation and international human rights instruments and international diagnostic schedule identify and recognise the seriousness of disruptive, impulse-

control, and conduct disorders, why then should medical practitioners not acknowledge the seriousness of mental health care services for children suffering from this category of disorder?

Similar to section 6 and 11 of the Children's Act, the Mental Health Care Act (preamble) highlights that the state is obliged to provide mental health care services to all persons in need of such facilities. Here, the aim is to provide care, treatment, and rehabilitation to persons, including children, who suffer from a mental disorder (Mental Health Care Act, preamble). Although the right to mental health care is stipulated under domestic legislation, resulting from South Africa's obligation to international human rights instruments, the rights of children suffering from psychiatric disorders such as ADHD, ODD and CD, are constantly infringed upon since there are limited services and service-providers who are adequately skilled to provide effective treatment to this group of children (Amicus Head, 2018:9).

National and international human rights instruments and legislation dealing with child offenders with psychiatric disorders promote the best interest of a child. For the purpose of the study, comparative procedures used to deal with child offenders with psychiatric disorders will be discussed below using African jurisdictions for comparison.

4.4 COMPARATIVE PERSPECTIVES

4.4.1 Botswanan human rights and legislative perspectives

Botswana became a signatory to the UNCRC (1990) in 1995 (United Nations Treaty Collection, 2017:01). Human rights and legislation which specifically pertain to children in conflict with the law in Botswana are dictated under the Botswana Constitution (2006), the Children's Act (2009) and the Botswana Penal Code (1964). In addition, and for the purpose of this study, legislation dealing with mental health is dealt with under the Botswana Mental Disorders Act (1961).

4.4.1.1 The Constitution of the Federal Republic of Botswana 2006

Section 1(h) and 5 of the Botswanan Constitution (2006), stipulates the protection of liberty and care and treatment of a person who is of unsound mind. This legislation is significant to this study since, similar to section 77 and 78 of the Criminal Procedure Act, this pertains to child offenders suffering from psychiatric disorders.

Section 7 of the Botswana Constitution provides a protective mantle against inhumane treatment. This protective obligation is echoed under article 37 of the UNCRC (1990), article 16 of the ACRWC (1990) and is similarly found under section 12(d) of the South African Constitution. The importance of this legislation is that children, who conflict with the law, whether suffering from a psychiatric disorder or not, are protected from degrading treatment and torture. It must be acknowledged that, although this is an international treaty stipulation, the complete practice is not implemented in most African countries (Winterdyk, 2013:1).

The Botswana Constitution (section 10) makes provision for the presumption of innocence until proven guilty. Similarly, section 35(3)(h) of the South African Constitution, section 7 of South African Child Justice Act, article 40 (i) of the UNCRC as well as article 17(i) of the ACRWC (1990) make provision for this protective presumption.

Although Botswana ratified the UNCRC (1990) and the ACRWC (1990), the Botswana Constitution (2006) does not make special provision for the best interests of the child as is the case with the South African Constitution. Legislation specific to child offenders with psychiatric disorders is dealt with under the Children's Act (2009), the Botswana Penal Code (1964) and the Botswana Mental Disorders Act (1961).

4.4.1.2 The Children's Act (2009)

Legislative procedures in the Botswana Children's Act (2009) are grounded in protecting and upholding the rights of children. Section 1 of the Children's Act (2009) defines a child as one who is younger than 18 years of age. Prior to the enactment of the Children's Act of Botswana in 1981, children in conflict with the law were dealt with under the same criminal procedure legislation used to deal with adults, namely, Botswana Penal Code (1964). The development and implementation of the Children's Act (2009) emerged as a result of the increase in children coming into conflict with the law and limited services, such as rehabilitation and/or detention in Botswana (Somolekae, 2009:2).

Like article 40(3) of the UNCRC (1990), and the South African Children's Act (section 7), the objective of Botswana's Children's Act (2009, section 4 & section 6)

is to provide full legislative protection to children and adolescents and to uphold the best interest standard in all matters concerning children. In upholding the best interest of the child, the objectives and guiding principles of the Act (Children's Act, 2009, section 3-8) include but are not limited to, protecting children from harm; attending to the child's emotional, physical, spiritual and educational needs and factoring age, level of maturity, gender and language into all decisions concerning children.

Section 61 and 27(4)(h) of the Botswana Children's Act (2009) is similar to article 37 (a-b) of the UNCRC (1990), section 12(d) of the South African Constitution and article 16(d) of the ACRWC (1990), which pertain to the protection of and best interest of children. Under this legislation, the child is protected from cruel, inhumane, and degrading treatment. Section 61(2) of the Children's Act (2009) not only protects all children from cruel and inhumane treatment, but also protects the child from unreasonable corrections and states that corrections are to be in proportion to the child's age, physical and/or mental condition (Botswana Children's Act, 2009, section 61(2) & 27(4h)). This legislation not only speaks to the protection of children but also recognises and specifies the protection of children suffering from mental conditions, such as psychiatric disorders.

Against the literature reviews, document analysis and research conducted by Geoffrey (2016), child offenders who suffer from psychiatric disorders are considered children in need of care and protection. Section 42(a, f & i) of the Children's Act (2009) outlines that a child in need of care and protection is one who has been abandoned or neglected, who is without parental care, who displays behaviour that the parent/guardian is unable to control and/or one who is in any situation that may negatively affect the child's physical, emotional, psychological and/or general well-being. Section 42 (f & i) (Children's Act, 2009) is similar to section 150 of the South African Children's Act and is important, since children with psychiatric disorders who conflict with the law exhibit uncontrollable behaviour and, due to their heightened anti-social behavioural tendencies, frequently find themselves in conflict with figures of authority.

Section 81 (Botswana Children's Act, 2009) stipulates that, should a child be accused of committing a criminal offence, it is the responsibility of the police officer

to investigate the offence and request the assistance of a social worker to file a report to children's court pertaining to the general conduct of the child's living environment, school records and medical history, if available. In dealing with a child offender, the children's court may: place the child under probation for a period of not less than six months, place the child in a school of industries for a period of not more than three years or until he has reached 21 years of age, sentence the child to community service for an appropriate period dictated by the court, sentence the child to corporal punishment and/or imprisonment (Children's Act, 2009, section 85).

Section 84 of the Children's Act (2009), stipulates that a child found guilty of an offence may be subjected to probation for a period of not less than 6 months or more than 3 years, be sentenced to corporal punishment and/or imprisonment if decided upon by the court. In respect to the best interest principle, the question arises how section 84 of the Botswana Children's Act (2009), meets the best interests of a child offender with a psychiatric disorder, if corporal punishment and/or imprisonment are inflicted upon a child found guilty of a criminal offence. The legislative actions dictated under section 84 (Children's Act, 2009), do not consider factors, such as the influence of a psychiatric disorder on the child's cognitive and conative processing, in relation to his criminal behaviour and the methods used to deal with this vulnerable group.

Children who suffer from psychiatric disorders are disabled by the influence the disorder has on their cognitive and conative processing. Like the South African Children's Act (section 6(2f)), section 52 of the Botswana Children's Act (2009) highlights that a child with a disability has the right to receive specialised care which promotes wellness and participation in social, cultural, religious, and educational activities based on the child's mental and physical capabilities. This legislation is similar to that stipulated in the UNCRC (1990, article 23a), the UNCRPD (2007, article 3 & 7) and the South African Children's Act (section 6(2f)), which recognises the special needs and rights of children with disabilities.

The child has the right to receive detailed information pertaining to the charges, sentence and penalties brought against him (Children's Act, 2009, section 86). Should the child fail to comply with the conditions of the charges, he will be liable to be sentenced for the initial criminal offence and/or any other penalties dictated by the

court (Children's Act, 2009, section 86). Botswana's legislation allows different penalties for first-time offenders, and repeat offenders. Section 88 of the Children's Act (2009) outlines that repeat child offenders shall be imprisoned for a period decided appropriate by the court and such a child shall be dealt with in terms of the Penal Code (1964).

4.4.1.3 Botswana Penal Code (1964)

In addition to the Botswana Children's Act (2009), child offenders with psychiatric disorders are dealt with in terms of the Botswana Penal Code (1964). As found in the UNCRC (1990a, article 2(b)(i)) and section 28(g) of the South African Constitution, the Botswana Penal Code (1964, section 13) provides a protective mantle for persons accused of a criminal offence. Under this legislation all persons' accused of committing a crime fall under the presumption of innocence until the contrary is proven beyond a reasonable double. This legislation applies to children and adults who conflict with the law.

According to section 13(1) of the Botswana Penal Code (1964), persons younger than 8 years of age fall under an irrebuttable presumption of innocence; this means that a child under this age cannot be held criminally liable for his misconduct.

A child, between 8 and 14 years of age, who comes into conflict with the law, is presumed innocent, unless it can be proven that, at the time of the alleged offence, the child had the capacity to understand the wrongfulness of his actions (Botswana Penal Code, 1964, section 13; Children's Act, 2009, section 82). According to section 27 of the Botswana Penal Code (1964), a child who is 14 years of age and younger cannot be subjected to imprisonment. This legislation, which protects children younger than 14 years of age, is similar to section 7 of the amended South African Child Justice Act, which stipulates that, a child between 12 and 14 years of age is presumed innocent, unless the state can prove beyond a reasonable doubt, that the child in question, at the time of the alleged offence, had the ability to appreciate the wrongfulness of actions and to act in accordance with that understanding.

According to section 28 of the Penal Code (1964), children sentenced to corporal punishment shall not receive more than six strokes. The practice of corporal

punishment, as also stipulated in the Botswana Children's Act (2009, section 85), is a direct violation of a child's human rights as well as a violation of the Botswanan ratification of the UNCRC (1990). This is evident, as according to article 37 (a-b) of the UNCRC, "...no child shall be subjected to torture, cruel or inhumane intentions..." such as the practice of corporal punishment.

Section 32 of the Botswana Penal Code (1964) deals with factors pertaining to the punishment of an accused who suffers from a mental health condition.

Similar to the South African Child Justice Act (section 48(5)) and the South African Criminal Procedure Act (section 77- 78); section 32 of the Botswana Penal Code (1964) stipulates that the court may discharge an offender accused of a criminal offence, without proceeding to conviction, if the court is of the opinion that inflicting punishment would be inexpedient due to mental illness, age and/or other factors. This legislation is of particular importance in the context of this study since it provides a protective legislative framework for child offenders who suffer from psychiatric disorders.

4.4.1.4 Botswana Mental Disorders Act 1971

Mental health care is dealt with in terms of the Botswana Mental Disorders Act (1971). According to section 2, a child is defined as a person under the age of 16, unless otherwise specified. This is of significance since section 1 of the Children's Act (2009) defines a child as one who is younger than 18 years of age. Children who come into conflict with the law, between 16 and 18 years of age, are excluded from the protection of the Mental Disorders Act but are however still protected under the Children's Act. It is with this in mind, that child offenders between these age brackets are considered vulnerable, due to a legislative contradiction which does not serve the best interest of the child.

The legal definition of a mentally disordered or defective person, according to the Botswana Mental Disorders Act (section 2), is:

"...any person who in consequence of a mental disorder or disease or permanent defect of reason or mind, congenital or acquired, is incapable of managing himself or his affairs, or is in consequence of such disorder or disease or defect a danger to himself or others, or is unable to conform

with the ordinary usages of the society in which he moves, or who in consequence of such disorder, disease or defect requires supervision of treatment or control, or who, if a child, appears by reason of such defect to be permanently incapable of receiving proper benefit from instruction in ordinary schools;...”.

This definition clearly outlines factors pertaining to persons of unsound mind, unable to conform to ordinary society, and who requires supervision, or a child who is incapable of receiving proper benefit from school instructions. As discussed previously child offenders with psychiatric disorders have trouble conforming to societal expectations, parental supervision, and scholastic instructions due to the impairments experienced in cognitive, conative and developmental processing. In addition to the impairments, these difficulties also worsen a child's predisposition to criminal conduct.

Section 3 of the Mental Disorder Act (1971) provides a classification of the mentally disordered as follows:

“(a) Class I: a person who is- (i) of suicidal or homicidal tendency or is in any way dangerous to himself or others; or (ii) has committed or attempted to commit any offence of a serious character;

(b) Class II: a person who, although not falling within Class I, is unable to guard himself against common physical dangers or to look after his person and who requires skilled medical attention;

(c) Class III: a person who, although not falling within Class I, is unable to guard himself against common physical dangers or to look after his person but who does not require skilled medical attention”.

Since the focus of this study only considers criminal offences committed by child offenders with psychiatric disorders, with the exclusion of the possibility of suicide attempts; child offenders with psychiatric disorders would likely be categorised under section 3(b) of the Mental Disorder Act (1971). It is against this background that a child offender with a psychiatric disorder requires additional protection in order to meet and protect his best interest.

The Mental Health Disorders Act (1971) (part III), makes a clear stipulation on the period of detention for persons of unsound mind who conflict with the law. Persons of unsound mind may not be held in detention for longer than 30 days, without medical assessment (Mental Health Disorders Act (1971, part III).

In cognisance of section 84 of the Children's Act, which outlines that a child found guilty of an offence may be subjected to probation for a period of not less than 6 months or no more than 3 years, or to corporal punishment and imprisonment if decided upon by the court; the question arises: if a child offender with a psychiatric disorder is found guilty, the Mental Disorder Act (1971, part III) makes clear that, the individual may not be detained for a period of longer than 30 days, without assessment.

Against the background of research, which identifies the lack of mental health services and service-providers in Botswana, are the best interests of Botswanan child offenders with psychiatric disorders met? Further, it is unclear from the legislation whether assessment takes place within 30 days of apprehension or sooner (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017).

The researcher avers that the Botswanan child justice legislation, as depicted above, does not adequately provide protection or services to meet the best interest standard. Child offenders, as well as child offenders suffering from psychiatric disorders, are subjected to untrained service-providers and underdeveloped legislation which infringe upon their rights. Although Botswana is a signatory to international child related treaties, it is imperative that Botswana aligns child justice legislation accordingly in seeking to meet the best interest standard as included in her legislative provisions.

Although attention is given to the child, research indicates a lack of legislative development, service development, institutional interventions, community support structures and mental health care facilities (Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550; Geoffrey, 2016: 172).

4.4.2 Nigeria human rights and legislative perspectives

Nigeria is a signatory to the UNCRC (1990). Since its ratification in 1991, Nigeria attempted to bring its legislation and human rights policies to par with international

human rights instruments and legislation (Ibraheem, 2015:50). In addition, Nigeria is also a signatory to other human rights conventions such as the Convention on the Elimination of all Forms of Discrimination Against Women, and the Convention against Torture and other Cruel Inhumane Degrading Discrimination (Ibraheem, 2015:49).

Human rights instruments and legislation pertaining to children are dictated by the Nigerian Constitution (1960), the Child's Rights Act (2003) and the Children and Young Persons Law of Nigeria (1990). Children in conflict with the law are dealt with in terms of two separate bodies of legislation. Children residing in the south of Nigeria are dealt with under the Nigerian Criminal Code (1916), whilst children residing in the north are dealt with under the Nigerian Penal Code (1960). This is in line with the federal system of political governance.

For this study, legislation dealing with child offenders, namely, the Nigerian Constitution (1999), the Children's Rights Act (2003) and Children and Young Persons Law of Nigeria (1990) will be discussed. In addition to these Acts, the Lunacy Act of 1958, used to deal with persons with mental illnesses, will be discussed.

4.4.2.1 The Constitution of the Federal Republic of Nigeria (1999)

Nigerian human rights are documented in the Nigerian Constitution (1999). Similar to the Botswanan Constitution (2006), Nigeria does not have a specific framework in the constitution that deals with the protection of children, or children in conflict with the law. A protective mantle which upholds the best interests of the child is stipulated in the Children's Act (2003), which will be discussed below.

According to section 21(4) of the Nigerian Constitution (1999), all persons accused of committing a criminal offence are protected by the presumption of innocence, unless the contrary is proven. Chapter IV outlines the general fundamental rights of Nigerian citizens. Similar to article 37(a)-(b) of the UNCRC (1990), section 34 of the Nigerian Constitution (1999) stipulates "...no person shall be subjected to torture, or to inhumane or to degrading punishment..." Additionally, section 34 and section 35 (Nigerian Constitution, 1999) promise rights to life, dignity, personal liberty, a fair

hearing for those who conflict with the law and the right to freedom of expression and movement and protection from discrimination.

4.4.2.2 The Child's Rights Act (2003)

The Child's Rights Act of Nigeria (2003) provides general legislative protection to the rights of the child. The objective of the Child's Rights Act (2003) is to provide and protect the rights of the children in Nigeria. In lieu of Nigeria's ratification of the UNCRC (1990), section 1 of the Act (Child's Rights Act, 2003) stipulates that, in every decision taken, the best interest of the child is of primary consideration. This is in accordance with the guiding principles of the UNCRC (1990).

The Child's Rights Act (2003) provides legislative protection pertaining to the well-being, rights and responsibilities of the child, and protection against physical, mental, emotional harm, maltreatment, torture, degrading punishment (section 9 & 11).

4.4.2.3 Children and Young Persons' law of Nigeria (1990)

The Children and Young Persons' law of Nigeria (1990) deals with children, and child offenders. Part 2 defines a child as one who is 14 years of age and younger and a young person as one who is between 14 and 18 years of age.

Children and young persons who find themselves in conflict with the law have the right to receive information pertaining to the criminal offence which they are accused of (Children and Young Persons' law of Nigeria, 1990, part 8, section 1). Part 15 of the Children and Young Persons' law of Nigeria (1990) makes the following provision for sentencing child and young offenders found guilty of an offence:

- "by dismissing the charge, or,
- by discharging the offender on his entering into a recognisance, or
- by so discharging the offender and placing him under the supervision of a probation officer, or
- by committing the offender by means of a corrective order to the care of a relative or other fit person, or

- by sending the offender by means of a corrective order to an approved institute, or
- by ordering the offender to be caned, or
- by ordering the offender to pay a fine, damages, or costs, or
- by ordering the parent or guardian of the offender to pay a fine, damages, or costs, or
- by ordering the parent or guardian of the offender to give security for his good behaviour, or
- by committing the offender to custody in a place of detention provided under this Law, or
- where the offender is a young person, by ordering him to be imprisoned, or
- where the offender is a young person by committing him to a Borstal institution, or
- by dealing with the case in any other manner in which it may be legally dealt with”

Part 8 (section 1) and part 15 (k-m), pertain to the right to receive information and deal with child offenders found guilty. As outlined above, Nigerian children, and furthermore all African children (ACRWC, 1990, article 4), enjoy the right to protection from harm and degrading treatment. The sentencing options discussed above, which include imprisonment, institutionalisation and caning raises questions as to whether child justice practitioners are cognisant of the individual needs and best interests of each child. Furthermore, it is evident that the approach taken to a child found guilty of a criminal offence is not holistic or multi-contextual.

Contradictorily, part 12(2) of the Children and Young Persons’ law of Nigeria (1990), stipulates that no child or young person shall be imprisoned if he can be dealt with suitably by the court, probation officer, parents/guardians, a fine, corporal punishment, a place of detention or other approved institution. It is of importance to note, as similarly reflected in the Botswanan legislation (Children’s Act 2009, section

85), the practice of corporal punishment, not only violates the child's basic human rights but also disregards section 1 of the Child's Rights Act (2003) and article 37(a-b) of the UNCRC. In this respect, the protection of the best interest of the child is questioned.

Children and young persons who are imprisoned shall not be allowed to interact with adult offenders (Children and Young Persons' law of Nigeria, 1990, part 12, section 3). Part 2 (section 3) (Children and Young Persons law of Nigeria, 1990), outlines that bail for a person younger than 17 years of age may be granted by a police officer, who releases the child to his parent in lieu of an amount stipulated by the police officer as assurance that the person will attend the hearing for the charges. This is unless the child/young person has been accused of homicide or a grave criminal offence, or unless the police officer has reason to believe that the release of the child would defeat the ends of justice (Children and Young Persons' law of Nigeria, 1990, part 2 (section 3)). Part 2 (section 4) (Children and Young Persons law of Nigeria, 1990) outlines that the custody of a child, who has not been granted bail, should remain as such until the child/young person is brought before the court, with exceptions of a child whose physical and/or mental health does not permit him to be detained. Certification must prove the latter.

As highlighted above, children in need of care and protection are of significance to this study. Part 5 of the Children's and young persons' law of Nigeria (1990) defines this vulnerable group of children as orphaned and/or homeless, children who have been subjected to maltreatment and/or children in danger of violation of their human rights. Based on the aim of this study, it is important to draw attention to the definition of 'a child in need of care and protection' in the Children's and young persons' law of Nigeria (1990), since it does not specify that a child in need of care and protection is one who suffers from a mental or physical disability, as dictated in South African Children's Act (section 150) and Botswanan law (Children's Act, 2009, section 42).

4.4.2.4 Nigerian Criminal Code (1916) and Penal Code (1960)

Similar to Botswanan (Children's Act, 2009) and South African legislation (Child Justice Act), Nigeria does not have specific legislation that deals with child offenders with psychiatric disorders. Child offenders with psychiatric disorders are dealt with

under the Nigerian Criminal Code (1916) and the Penal Code (1960), which are both adult-orientated bodies of law.

According to the Nigerian Criminal Code (1916) and the Nigerian Penal Code (1960), children who are seven years of age and older may be held criminally responsible. However, the onus rests on the state to prove, that at the time of the alleged offence, the child in question had the ability to appreciate the wrongfulness of his actions and act in accordance with that appreciation. The minimum age of criminal responsibility in Nigeria is not aligned in terms of article 40(3a) of the UNCRC (1990) and therefore does not uphold the best interests of the child in terms of legislation on criminal capacity. According to Nigeria's ratification of the UNCRC (1990), she is obliged to create and improve child justice legislation and policies and to align with the UNCRC (1990).

According to section 28 of the Nigerian Criminal Code (1916), a person, shall not be held criminally liable for his actions, if at the time of the alleged offence, he suffered from a mental disorder or illness that deprived him of the capacity to fully understand and appreciate the wrongfulness of the misconduct. This legislation recognises the impact of a mental illness/psychiatric disorder on a person's cognitive and conative abilities and is similar to that stipulated under the South African Child Justice Act (section 48 (5)), the South African Criminal Procedure Act (section 77- 78) and the Botswana Penal Code (1964, section 32).

In addition to the Criminal Code (1916) and Penal Code (1960), children suffering from mental disorders are also dealt with in terms of the Lunacy Act (1958).

4.4.2.5 Lunacy Act of 1958

Since the focus of this study is child offenders with psychiatric disorders, it is of importance to make a clear specification that, child offenders with psychiatric disorders are dealt with in terms of the Lunacy Act (1958). Although a bill relating to the Mental Health Care Act of 2013 has been developed, the new act has not yet been promulgated in Nigeria and this study thus relies on the Lunacy Act (1958).

According to Ude (2015:2), citing the Lunacy Act (1958), the definition of mental illness includes, "...mental illness as lunacy; and according to this law, 'lunatic'

includes idiots and any persons with unsound mind...". This definition is in direct conflict with the South African Mental Health Care Act (section 1) which defines mental illness as "...a positive diagnosis of mental health-related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis".

The definition of a mental illness/psychiatric disorder in mental health care legislation plays a vital role in dictating which children with psychiatric disorders receive services (Boezaart & Skelton, 2011:18). According to Ude (2015:5), the Lunacy Act allows magistrates and medical practitioners to determine who is a lunatic, and furthermore when and how long to detain the accused. In this light, although the Child and Young Persons' law of Nigeria (1990), Nigerian Child's Rights Act (2003), Criminal Code (1916) and Penal code (1960) make clear specification of the time-frame allowed to deal with a child offender with a psychiatric disorder, the Lunacy Act (1958), leaves this to the discretion of the magistrate and/or medical practitioner.

Further to this, Ude (2015:2) outlined that the Lunacy Act (1958) grants the authority to detain a 'lunatic' without treatment for a period of 7 days. The concern here is if a child offender with a psychiatric disorder is found to be mentally ill, or as referred to in the Lunacy Act (1958) a lunatic, the child will then be detained for a period of 7 days for testing without treatment. The argument here is that this is a direct violation of the child's rights to receive health care services based on his disability as well as a direct violation of international treaties (UNCRC, 1990; ACRWC, 1990) pertaining to the best interests of the child.

Despite the ratification of international treaties and development in juvenile justice legislation, it is evident that there is a lack of legislative and practical development pertaining to child justice in Nigeria. Causative factors, as discussed in chapter 3, are still not identified or taken into consideration when dealing with this vulnerable group in Nigeria.

According to UNICEF (2017:1), the rise in children in conflict with the law in Nigeria is a dire concern. Many incarcerated children are wrongfully detained and subjected to cruel, brutal conditions in prison. Reports have documented children imprisoned with older groups of children, due to incorrect age estimations (UNICEF, 2017:1).

The task of dealing with child offenders is complex and as a result of the under-developed legislation, outlined above, the best interests of child offenders with psychiatric disorders are not treated as a priority. The lack of legislative protection, specifically for children, in the Nigerian Constitution (1999) as well as the Child's Rights Act (2003), Criminal Code (1916) and Penal Code (1960), does not act in the best interests of the child. With this, the inclusion of a specific child justice clause, such as section 28 of the South African Constitution, would be a positive legislative development to the best interests of the child in Nigeria.

4.4.3 Namibia human rights and legislative perspectives

Namibia ratified the UNCRC in 1990 (United Nations Treaty Collection, 2017:01). Since ratification, Namibia has incorporated the objectives and guiding principles of the UNCRC (1990) into her legislation in an attempt to act in the best interests of the child. Children with psychiatric disorders, who conflict with the law, are dealt with under the Namibian Constitution (1998), Child Care and Protection Act (2015), Criminal Procedure Act of Namibia (2004) and the Mental health Act of Namibia.

4.4.3.1 The Constitution of the Republic of Namibia (1998)

Chapter 3 of the Namibian Constitution (1998) provides legislative guidelines for fundamental human rights and freedom. Of significance to this study are articles 6 to 8 and articles 11, 12 and 15. Under article 6 (Constitution of Namibia, 1998), legislative provision is made for the protection of life. Here it stipulates that no person shall be subjected to death as a component of punishment. Similar to article 37(a-b) of the UNCRC (1990) and article 16 of the ACRWC (1990), article 8 of the Constitution of Namibia (1998) highlights the right to human dignity. Under this article (Constitution of Namibia, 1998, article 8), no person, shall be subjected to torture, cruel, inhumane, or degrading treatment.

It is interesting to note that, unlike the Botswanan Constitution (2006) and the Nigerian Constitution (1999), the Namibian Constitution (1998) places emphasis on the best interest standard. In this respect, article 15 of the Namibian Constitution (1998) outlines that children are subject to legislation enacted on the best interest standard. Factors pertaining to the best interests of the child are also highlighted under the Child Care and Protection Act of Namibia (2015).

According to article 11 (Constitution of Namibia, 1998), no persons, shall be detained without an indication of the accusation or charges brought against him and all arrestees ought to be brought before a magistrate or judge within 48 hours of their arrest, or the closest time possible thereafter. Article 12 (Constitution of Namibia, 1998) highlights that judgements, other than those for juvenile offenders, will be given in public. In addition, article 12 (Constitution of Namibia, 1998) echoes article 2b(i) of the UNCRC (1990) on the presumption of innocence until proven guilty. No child, under 16 years of age, shall be detained (Constitution of Namibia, 1998, article 15). The Constitution of Namibia (1998, article 12(1a)) stipulates that all persons, who conflict with the law have the right to a fair trial.

4.4.3.2 Child Care and Protection Act of Namibia (2015)

The objectives of the Child Care and Protection Act of Namibia (2015) include protecting and promoting the well-being of children, developing, and improving structures pertaining to the needs of the child and families and providing protective measures for children in need of services due to mental or physical disabilities. Here, a child is defined as one who has not yet reached the age of 18 years.

Section 3 of the Child Care and Protection Act of Namibia (2015) emphasises the principle of the best interest of the child. Here, it is stipulated that in determining the best interest of the child, factors such as the child's age, maturity and background, stage of intellectual, emotional, and social development, any disability the child may have, or maltreatment suffered, ought to be taken into consideration. According to section 9 of the Child Care and Protection Act of Namibia (2015), every child with a disability has the right to care and protection pertinent to his condition and which upholds the child's best interest.

A child in need of care and protection is outlined as one who has been abandoned and/or is homeless, who portrays behaviour that is harmful to himself or those around him, who exhibits uncontrollable behaviour, who has experienced physical and/or mental maltreatment, who is abusing substances and/or who is under 18 years of age and involved in criminal behaviour (Child Care and Protection Act of Namibia, 2015, section 131 (1)). In this case, a child in need of care and protection will be referred to a social worker for investigation and intervention (Child Care and Protection Act of Namibia, 2015, section 131 (2)). Based on the definition of a child

in need of care and protection, a child offender who suffers from a psychiatric disorder would be included there. Children who are detained have the right to be held separately from adults and ought to experience conditions that are conducive to their wellbeing and best interests (Child Care and Protection Act of Namibia, 2015, section 231).

Section 228(3) (Child Care and Protection Act of Namibia, 2015) demonstrates Namibia's legislative obligation to the UNCRC (1990) by outlining that no child shall be subjected to corporal punishment. This legislation honours article 37(a-b) of the Convention (UNCRC, 1990) by upholding the child's rights to freedom from torture, cruel or inhumane intentions.

4.4.3.3 Criminal Procedure Act of Namibia (2004)

Similar to child justice legislative practice in South Africa, Botswana and Nigeria; Namibia does not have a separate legislative framework that deals with criminal procedures for child offenders with psychiatric disorders. Hence, in addition to the Constitution of Namibia (1998) and the Child Care and Protection Act of Namibia (2015), child offenders with psychiatric disorders are dealt with in terms of the Criminal Procedure Act of Namibia (2004). The application of this Act to this vulnerable group of children does not meet the best interests of a child or uphold Namibia's obligations to international treaties such as the UNCRC (1990).

Section 76 of the Criminal Procedure Act of Namibia (2004) provides a protective measure for a child offender found guilty of a criminal offence. In this regard, the child may be placed in a place of safety instead of released on bail or detention. According to Ude, (2015:343) although the Criminal Procedure Act of Namibia (2004) makes provision for places of safety for child offenders, section 1 of the Children's Act of Namibia (as cited in Ude, 2015:353) defines police stations as a place of safety.

Similar to sections 77 and 78 of the South African Criminal Procedure Act (1977), the Criminal Procedure Act of Namibia (2004, section 88) stipulates that courts may discharge an offender accused of a criminal offence, without proceeding to conviction, if the court is of the opinion that inflicting punishment would be inexpedient due to mental illness, age and/or other factors. This legislation provides

a protective legislative framework for child offenders who suffer from psychiatric disorders as well as for child offenders who are considered too young to fully appreciate the wrongfulness of their actions.

In addition to the previously mentioned legislation, children suffering from psychiatric disorders, who conflict with the law, are dealt with in terms of the Mental Health Act of Namibia (1973).

4.4.3.4 Mental Health Act 18 of 1973 (RSA) Namibia

The Mental Health Act 18 of 1973 (section 1) defines mental illness as, "...any disorder or disability of the mind, and includes any mental disease, any arrested or incomplete development of the mind and any psychopathic disorder, and 'mentally ill' has a corresponding meaning".

In addition to the definition of mental illness, it is of significance to elaborate on the definition of a psychopathic disorder. Section 1 (Mental Health Act, 1973) defines a psychopathic disorder as, "...a persistent disorder or disability of the mind (whether or not sub-normality of intelligence is present) which has existed in the patient from an age prior to that of eighteen years and which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and 'psychopath' has a corresponding meaning;..."

This definition, of a psychopathic disorder, (Mental Health Care Act, 1973, section 1) raises concern since child offenders with psychiatric disorders, such as ADHD, ODD, CD, can be diagnosed with a psychopathic disorder, due to the terminology defining same (DSM-5, 2013: 33, 59,60,66-67, 462,470-473). According to Croft (2016:1), a psychopathic disorder is referred to as psychopathy in an anti-social personality disorder. The DSM-5 (2013:745) does not make specific provision for the diagnosis of psychopathic disorder; however, characteristics of psychopathy are documented under the anti-social personality disorder. The contradiction here lies in the definition used in the Namibian Mental Health Act (1973, section 1), of psychopathic disorder, in comparison to the definition used in the DSM-5 (2013:745) of an anti-social personality disorder, with psychopathic traits.

Section 30(1) and section 30(4) of the Mental Disorders Act (1973) outlines that care for individuals deemed mentally-ill is provided by hospital-prisons for psychopaths. The term psychopath is used loosely. In this respect, child offenders, with psychiatric disorders, such as ADHD, ODD and CD, could be unduly diagnosed and/or grouped as having a psychopathic disorder. The concern arises here, as to the treatment protocol and methods of practice used to deal with this vulnerable group of children, since Namibian health care legislation does not deal with the best interest of child offenders, and furthermore child offenders with psychiatric disorders.

According to the Ministry of Health and Social Services on the National Policy for Mental Health in Namibia (2005:5), approximately 3600 children, under 15 years of age, suffer from serious mental health problems, and approximately 7200 children, under 15 years of age, suffer from learning or behavioural problems. It is important to note that, in its concluding remarks, this report identified that the figures documented are likely to be an underestimation due to the fact that mental health workers, do not have the necessary training to detect mental disorders (Ministry of Health and Social Services on the National Policy for Mental Health in Namibia, 2005:5). A lack of trained service-providers and services which specifically deal with persons suffering from mental disorders hamper the treatment and rehabilitation of individuals who need such care.

It is evident from the aforementioned legislative guidelines that, although the best interest standard is outlined in Namibian child justice legislation, there is a lack of emphasis on the best interests of each child offender from a case-specific perspective. In addition, research outlining the lack of mental health care facilities in Namibia violates section 9 of the Child Care and Protection Act of Namibia (2015), which promises the child's rights to receive basic care pertaining to his special needs and disabilities. Thus, the best interest standard in Namibia is regarded as limited and not holistically implemented.

4.5 JUDICIAL INTERPRETATION

Since this chapter focuses on the best interest standard, it is essential to include judicial interpretation demonstrating if and the extent to which the best interest

standard is exercised, in upholding the rights of child offenders with psychiatric disorders and children who come into conflict with the law.

In *McCall v. McCall* 1994 (3) SA 2001, the best interest of the child was explored, and the court provided a compilation of best interest standards that should be used when dealing with children. Although the content of this case was not specific to children with psychiatric disorders, or child offenders, the courts concluding remarks pertaining to the best interest standard is of significance to this study. Factors from the best interest standard recommendation, which will be explored in detail below, included elements similar to those found in section 7 of the South African Children's Act, namely, stage of development, physical, emotional, intellectual, social and cultural development and security, any disabilities, background and any other relevant factors. The researcher is of the opinion that, although limited, these factors, in addition to other factors which will be explored later in this chapter, are considered relevant in determining the causative and predisposing factors for children in conflict with the law.

In *Centre for Child Law v MEC for Social Development, Gauteng* matters concerning the provision of services to children with severe disruptive behaviour disorders were dealt with. Since a settlement was reached on this case, the arguments prepared by the various child justice professionals were never argued or reported. However, research provided by the Centre for Child Law is of invaluable significance to this study since it specifically deals with child offenders with psychiatric disorders.

The children focused on in *Centre for Child Law v MEC for Social Development, Gauteng* suffered from neurodevelopmental, disruptive, impulse-control, and conduct disorders and bipolar mood disorders (Amicus Heads, 2018:5). ADHD, ODD and CD were prevalent.

Evidence (*Centre for Child Law v MEC for Social Development, Gauteng*) found that there were no long-term services equipped to address and provide effective treatment to children suffering from disruptive, impulse-control, and conduct disorders (Amicus Head, 2018: 6,17). Staff presently used to deal with this group of children are ill-equipped, not trained and do not have the skills to conduct multi-disciplinary assessments to determine the best interest or needs of this group of

children (Amicus Head, 2018:18). Consequently, these children are placed in schools, residential care facilities or therapeutic programmes which are inappropriate and where the service-providers are ill-equipped to deal with them. Due to the severity and disruptive, defiant behaviour manifested by this group of children, and inadequacies of the service-providers, these children are soon moved to new facilities, which are equally unsuitable (Amicus Head, 2018:6). The instability experienced by the child, from the continuous cycle of placement and removal to new care facilities is found to exacerbate the symptoms of the disorder and diminishes hope for positive long-term rehabilitation and an improved quality of life (Amicus Head, 2018:6; Bhandari, 2016:1; Royal College of Psychiatrists, 2014:1).

Based on these findings (Signed Court Order, 2018:7), the argument of the best interest standard is raised. Agreements stemming from this case include:

“15.1. Appropriate prevention and early intervention programmes, that accord with international best practices, for children at risk of developing severe or profound disruptive behaviour disorders, within their families and communities as far as possible.

15.2. The appropriate spread of residential care programmes, for those children who are in need of care and protection, that offer a range of programmes, that accord with international best practices that are specifically geared towards catering for children with severe or profound disruptive behaviour disorders.”

This agreement and recommendations not only outline the lack of resources that are available but also the need for improved services and necessary measures to ensure services for children suffering from disruptive, impulse-control, and conduct disorders. According to this report (CCL Heads of Argument, 2018:7), to ensure that the best interests of this group of children; the state must compel governmental departments to uphold their constitutional obligations.

In this light, regular follow-ups and service plan reports on progress were requested. To meet the best interests of child offenders suffering from psychiatric disorders, the state must be held to the international obligations pertaining to the rights of children and persons with disabilities (CCL Heads of Argument, 2018:7). In this light, training

of professionals to educate and provide better services to child offenders with psychiatric disorders, individualised and case-specific support measures, a multi-disciplinary team for assessments and regular follow-ups, assessment protocol for early identification based on the multi-disciplinary teams assessment pertaining to the individual disabilities of the child, are necessary (Amicus Head, 2018:10-12). Thus children suffering from psychiatric disorders who conflict with the law, should be dealt with in terms of an inter-sectional approach from governmental departments, namely Department of Social Development (DSD), DOJ&CD, Department of Education (DoE) and Department of Health (DoH) in order to ensure collaborative treatment and further placement and services (Amicus, 2018:20). The feedback and findings from this case (*Centre for Child Law v MEC for Social Development, Gauteng*) were in-line with recommendations and findings from this study, explored in chapter 5 and 6.

In *YG and the State SA (2016)*, a parent was charged with assault with intent to do grievously bodily harm to a child (9 years old). Once again, although this case is not specific to children in conflict with the law, since this chapter places emphasis on the best interest standard and the practice of corporal punishment, this case is of relevance. Details from this case (*YG and the State SA (2016)*) outlined that, the father, in an attempt to discipline his child, violently beat him. The assault was confirmed by medical reports. However, the fathers' plea indicated that he was merely disciplining his child, due to inappropriate behaviour, and any further physical harm inflicted upon the child was not as a result of the discipline but rather as a result of playing sports. As discussed above, African countries, such as Botswana and Nigeria, presently practice corporal punishment, if the court sees fit. In matters such as these, where there is physical violence inflicted on the child, there is an infringement of the child's basic rights and a failure to uphold the best interest standard. Although South Africa does not permit corporal punishment as a sentence, it is clear from the aforesaid case that it is still an 'accepted' practice, termed as discipline, in some families.

The brief discussion of the aforesaid cases merely scratched the surface of cases dealing with children in conflict with the law, child offenders suffering from psychiatric disorders and the best interest standard for child offenders. It is however clear that

despite the courts trying to factor the best interest standard it is nigh on impossible to categorise the best interests of all children into a quantifiable list. In addition and in support of the judicial interpretation on the best interest standard of the child: a comparative analysis of the best interest standard for child offenders with psychiatric disorders in comparative jurisdictions is demonstrated under table 6; as well as the inclusion of child justice practitioners to deal with child offenders with psychiatric disorders in table 8 and recommendations for improvement in child justice legislation in table 9..

In the section to follow, the best interest standard will be explored.

4.6 BEST INTEREST STANDARD

When dealing with child offenders with psychiatric disorders, it has been established that taking into account the best interest of the child is paramount and is, therefore, one of the focal areas of this study.

The best interest standard is outlined in international human rights instruments (UNCRC, 1990, article 3; ACRWC, 1990, article 4) and domestic legislation (South African Constitution, 1996: section 28; Children's Act: section 9; Child Justice Act: section 80). Although the aforementioned human rights instruments and domestic legislation highlight the best interest standard, the emphasis is not always applied to meet the individualised needs of the child and specific terms differ to varying degrees.

For example, terminology in the South African Constitution (section 28(2)) is stipulated as follows: "A child's best interests are of paramount importance in every matter concerning the child". In the ACRWC (1990, article 4) it is stipulated as "In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration". Under the UNCRC (1990, article 3) it is defined as: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration".

Although, all these human rights instruments and laws highlight the best interest principle, the terminology, 'paramount importance' (South African Constitution,

section 28(2)) creates the ideology that the child's best interest takes superiority over all other matters concerned. Whereas, the terminology 'primary consideration' creates the ideology that the child's best interest is the main concern (UNCRC, 1990, article 3, ACRWC, 1990, article 4). The legislative stipulation providing such protection pertaining to the child's best interest is ideal; however, the appropriate application and implementation thereof is questionable.

According to Comment 10 of the General Committee on the Rights of the Child (UNICEF, 2014:96), the best interests of a child who comes into conflict with the juvenile justice system, should be of primary concern. This is of significance since there is a clear distinction made between the best interest of child offenders and the best interest of the child. In addition, Comment 10 (UNICEF, 2014:96) highlights the differences between adult and child offenders regarding their physical, psychological, emotional, and educational development. "These differences constitute the basis for the lesser culpability of children in conflict with the law" (General Committee on the Rights of the Child, UNICEF, 2014:96). This statement is of importance and substantiates the aim of this study; which is to recommend a trans-disciplinary approach for dealing with child offenders with a psychiatric disorder. Here recommendations will be made pertaining to the individualised needs of child offenders who suffer from a psychiatric disorder(s), in legislation as well as practice. The argument supporting the aim and objectives of this study is the need to combine child justice legislation, namely the Children's Act, Child Justice Act and parts of the Criminal Procedure Act, so that children with psychiatric disorders are dealt with under one body of legislation; instead of the present approach whereby children with psychiatric disorders are dealt with under adult legislation, as highlighted above. With this, specific focus will be drawn to the needs of a child offender with a psychiatric disorder and the child will be dealt with from a multi-contextual, case-specific perspective.

Against the background of this argument, and in cognisance of the present legislation and methods of practice, the question arises, if and how are the best interests of a child offender with a psychiatric disorder upheld? The argument pertaining to the need for revision of current legislation and methods of practice used to deal with child offenders with psychiatric disorders is further strengthened when

the influence of psychiatric disorders and their effects in relation to behaviour are considered.

Comment 14 of the General Committee on the Rights of the Child (UNICEF, 2014:97), highlights the best interest principle in relation to the best interest of society. Here, it is stipulated that “The Committee acknowledges that the preservation of public safety is a legitimate aim of the justice system. However, it is of the opinion that this aim is best served by full respect for and implementation of the leading and overarching principles of juvenile justice enshrined in CRC”. This implies that, although the best interest of the child is paramount or of primary importance, it can be disregarded/limited if a child conflicts with the law and infringes upon the rights of society by committing a criminal act. With this, the best interest of society will take precedence over the best interest of the child, since the child has violated the rights of society by committing the criminal act.

According to Karels (2015:66), such stipulations reflect the legislative difficulties experienced in balancing the rights of society, to be protected from criminal acts, versus the rights of the child and his best interest. Furthermore, if section 28(2) of the Constitution emphasises the best interest standard, the detention of a child offender suffering from a psychiatric disorder does not meet the best interest of the child, since a child with this vulnerability requires holistic intervention pertaining to his special needs.

However, against the focus of this study, detaining the child offender, which may be viewed in the best interest of society, is a short-term solution. This is because the cycle of recidivism will continue since the child offender will not receive the needed care or corrective measures to reduce anti-social behaviour and prevent criminal behaviour. As discussed in chapter 2 and 3 of this study, causative factors influencing criminal behaviour and the development of psychiatric disorders must be addressed, as a primary concern, in order to meet the best interest of a child offender suffering from psychiatric disorders. This, in turn, will also meet the best interest of society since criminal offences committed by young offenders will be prevented and reduced.

Furthermore, a failure to meet the best interest of this group of children, due to limited service-providers and services, creates a cycle of perpetuation since the predisposing factors which caused the child to commit the criminal behaviour are not addressed.

Karels (2015:69) avers that to meet the best interest of the child, child justice practitioners must adopt a case-by-case approach and focus on the individualised needs of each child offender. This premise does not imply that the criminal offence should be excused, against the base of section 28 (South African Constitution) but rather signals a change of approach to dealing with this vulnerable group, which upholds the rights of society, whilst protecting the best interests of the child. In this light, creating a balanced child justice system is recommended, as highlighted above in the aim and objectives of this study.

According to Comment 15 of the General Committee on the Rights of the Child (UNICEF, 2014:97), a juvenile justice system should include elements which are of primary concern to the child. These include the prevention of juvenile delinquency, interventions without resorting to judicial procedures, appropriate age of criminal responsibility, upper-age limits for juvenile justice, the guarantee to a fair trial and prevention of deprivation of liberty, which includes pre-trial detention and post-trial incarceration.

In determining a framework to assess if and to what extent the best interest of the child standard is met, the Children's Act (section 7 and 11) makes specific legislative provision, as documented above. Further to this, findings from *McCall v. McCall* 1994 (3) SA 2001 also made the factors that should be used to assess if the best interest of the child is met. As mentioned, although the contents of this case did not pertain to child offenders with psychiatric disorders, the best interest standard recommended by the court is of relevance to this study. These factors included age, maturity, stage of development, physical, emotional, intellectual, social, and cultural development and security, any disabilities, background, and any other relevant factors (*McCall v McCall* 1994 (3) SA 2001). It must be acknowledged that these factors are also similarly reflected in section 7 of the Children's Act and will be used to conduct the comparative analysis of the best interest standard for child offenders with psychiatric disorders in comparative jurisdictions considered here.

In addition to understanding the best interests of children in conflict with the law, it is essential to take into consideration the best interests of a child with a psychiatric disorder. These factors will also be clearly outlined and discussed under 4.7 as a recommendation of factors that can be used to assess if the best interest of the child offender with a psychiatric disorder are upheld.

4.7 COMPARATIVE ANALYSIS OF THE BEST INTEREST STANDARD FOR CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS

Whilst it is true that it is impossible to specifically identify each and every aspect of what constitutes the best interests of a child; the researcher has identified certain aspects or criteria (from legislation and judicial interpretation) that must be taken into account when determining the best interests of a child offender. The table below identifies aspects of best interests specific to children with psychiatric disorders who conflict with the law. The researcher then determines the degree to which each comparative jurisdiction protects these interests, or fails to do so, within the bounds of its current legislative practice and procedure. Where the researcher wishes to extrapolate her thinking, she does so by means of footnotes.

**TABLE 6: A COMPARATIVE ANALYSIS OF THE BEST INTEREST STANDARD FOR
CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS IN COMPARATIVE
JURISDICTIONS**

	SOUTH AFRICA		NAMIBIA		BOTSWANA		NIGERIA	
ASPECT OF BEST INTEREST STANDARD SPECIFIC TO CHILDREN IN CONFLICT WITH THE LAW SUFFERING FROM PSYCHIATRIC DISORDER	YES	NO	YES	NO	YES	NO	YES	NO
a.) Age ¹		X		X		X		X
b.) Maturity ²								
c.) Stage of development ³						X		
d.) Background ⁴								
e.) Physical Security ⁵		X		X		X		X ⁶
f.) Emotional Security ⁷		X		X		X		X
g.) Intellectual Security ⁸								
h.) Social Security ⁹								X
i.) Cultural development ¹⁰		X		X		X		X

¹ Discussed earlier in this chapter from the UNCPRD (2007, article 3 and article 7) . Children's Act section 7 (g). Although, the age of criminal capacity is out of the scope of this study, in respect to meeting the best interest standard, of children in conflict with the law, South Africa, Namibia, Botswana and Nigeria minimum age of criminal responsibility is not aligned with the UNCRC (1990). In addition to the minimum age of criminal capacity for children, the minimum age of criminal capacity for child offenders with psychiatric disorders needs to be taken into consideration, since this group of children experience prefrontal cortex impairments, which will manifest as their intellectual, psychological and emotional development younger than their biological age; *McCall v McCall* 1994 (3) SA 201 (CPD).

² Discussed earlier in this chapter; from the UNCPRD (2007, article 3 and article 7). Children's Act section 7 (g). Factors pertaining to the emotional, psychological, social, and intellectual maturity of the child needs to be taken into consideration (...). This is specifically imperative for child offenders suffering from psychiatric disorders; *McCall v McCall* 1994 (3) SA 201 (CPD).

³ South African Children's Act section 7 (g); *McCall v McCall* 1994 (3) SA 201 (CPD).

⁴ South African Children's Act section 7 (g); *McCall v McCall* 1994 (3) SA 201 (CPD).

⁵ South African Children's Act section 7 (h); *McCall v McCall* 1994 (3) SA 201 (CPD)

⁶ Refer to section 4.4.2.5 to substantiate; *McCall v McCall* 1994 (3) SA 201 (CPD).

⁷ South African Children's Act section 7 (h); *McCall v McCall* 1994 (3) SA 201 (CPD).

⁸ South African Children's Act section 7 (h); *McCall v McCall* 1994 (3) SA 201 (CPD).

⁹ South African Children's Act section 7 (h); *McCall v McCall* 1994 (3) SA 201 (CPD).

¹⁰ South African Children's Act section 7 (h); *McCall v McCall* 1994 (3) SA 201 (CPD).

j.) Disabilities ¹¹		X		X		X		X
k.) Stability of family ¹²						X		
l.) Stability of environment ¹³						X		
m.) Protection from physical harm ¹⁴		X		X		X		X
n.) Protection from psychological harm ¹⁵		X		X		X		X
o.) Maltreatment ¹⁶		X		X		X		X
p.) Other relevant factors ¹⁷								
q.) Special care ¹⁸		X		X		X		X
r.) Support services ¹⁹		X		X		X		X
s.) Cognitive ²⁰		X				X		
t.) Moral ²¹		X		X		X		X
u.) Emotional ²²		X		X		X		X ²³
v.) Psychological ²⁴		X		X		X ²⁵		X
w.) Social ²⁶		X						
x.) Constitution outline BIS	X		X			X	X	
y.) Children's Rights and/or Acts	X		X		X		X	
z.) Holistic approach		X		X		X		X

¹¹ South African Children's Act section 11; *McCall v McCall* 1994 (3) SA 201 (CPD).

¹² South African Children's Act section 11.

¹³ Discussed in chapter 4; from the UNCRPD (2007, article 3 and article 7). South African Children's Act section 11.

¹⁴ South African Children's Act section 11.

¹⁵ South African Children's Act section 11.

¹⁶ South African Children's Act (section 7(h)). Child maltreatment includes, but is not limited to, abuse, neglect, exposure to violence, harmful behaviour.

¹⁷ South African Children's Act (section 7(h)).

¹⁸ South African Children's Act (section 7(h)).

¹⁹ South African Children's Act section 11.

²⁰ Discussed in chapter 4; from the UNCRPD (2007, article 3 and article 7). South African Child Justice Act, section 11(3).

²¹ South African Child Justice Act, section 11(3).

²² South African Child Justice Act, section 11(3).

²³ Refer to section 4.4.2.1 to substantiate. South African Child Justice Act, section 11(3).

²⁴ South African Child Justice Act, section 11(3).

²⁵ Refer to chapter 4 to substantiate.

4.8 CONCLUSION

The contents of this chapter focused on national and international human rights instruments and legislation which deals with child offenders with psychiatric disorders, in South Africa Nigeria, Botswana, and Namibia. Findings from the document analysis conducted in this chapter found that, due to inadequacies in legislation and practice, the rights of child offenders suffering from a psychiatric disorder(s) are infringed upon and this vulnerable group are receiving fragmented services, if at all.

The need for refined child justice legislation, which specifically deals with child offenders with psychiatric disorders was highlighted under the legislative analysis since at present children who come into conflict with the law, with psychiatric disorders, are dealt with under adult legislation. This legislative practice is poor and does not holistically address the special needs of the child and furthermore, the special needs of a child offender suffering from a psychiatric disorder. To align itself with international human rights obligations, namely the ratification of the UNCRC (1990), South Africa, as well as the select African countries need to actively focus on, develop and implement a multi-disciplinary approach to dealing with children in conflict with the law, and child offenders with psychiatric disorders. By adopting a multi-disciplinary, case-specific approach, steps can be taken towards meeting the best interests of child offenders with psychiatric disorders.

Findings from the empirical document analysis identified legislative and practical issues in the child justice and mental health sector and therefore informed the development of the semi-structured interview schedule which was used to conduct interviews with the child justice experts. The findings from the semi-structured interviews will be explored in the chapter to follow.

CHAPTER 5

PRESENTATION OF FINDINGS FROM SUBJECT EXPERT INTERVIEWS

5.1 INTRODUCTION

The contents of this chapter, which is the second phase in data collection, offers an analysis and presentation of the research findings from interviews with subject experts. As opposed to the first empirical chapter, which analysed child justice legislation, this chapter will focus on the influence of psychiatric disorders on childhood delinquency, methods of practice, legislation, and best interest standard for child offenders with psychiatric disorders. Here, the experiences, opinions, and recommendations; about improvements in legislation, methods of practice and the best interest standard; from child justice experts were employed to develop an improved, trans-disciplinary framework that can be used to deal with child offenders suffering from psychiatric disorders.

5.2 METHODOLOGY

As mentioned in chapter 1, a qualitative approach was followed, and data was collected making use of semi-structured; individual, telephonic, and face-to-face interviews.¹ Interviews were conducted with experts in the field of child justice and mental health, namely, psychologists, psychiatrists, social workers, probation officers, criminologists, legal representatives, and academics.

The presentation of the research findings was divided into six sections.

Section 1 focused on the demographic information of research participants. Here, the participants' profession, professional experience, and function in working with child offenders, children with psychiatric disorders and/or child offenders with psychiatric disorders were outlined. Participants were provided with the option of remaining anonymous or to waive their right to anonymity. The identities of the participants who waived their right to anonymity were included in the presentation of findings.

¹ Refer to chapter 1 on the research methodology applied in this study.

Section 2, which stemmed from objective 2,² focused on participants' opinions pertaining to the definition and categorisation of neurodevelopmental and disruptive, impulse-control, and conduct disorders, prevalent psychiatric disorders found in child offenders; and the extent to which these experts encounter this group of children. Opinions were also expressed on a perceived correlation between the severity of psychiatric disorders, particular criminal offences and the severity of the offence committed.

Section 3 explored the causative factors pertaining to the development of psychiatric disorders and criminal behaviour. This section spoke to objective 3 of the study. Here, attention was placed on the influence of psychological, biological, social, and environmental factors in relation to brain development, psychiatric disorders, criminal behaviour and the five developmental domains.

Stemming from objective 1, section 4 explored and presented findings pertaining to domestic child justice legislation. Here, the child justice process, adequacy of the child justice legislation and recommendations for legislative development and improvement was outlined.

In section 5, the services available to South African child offenders both in the child justice system, as well as once they leave the child justice system, were explored and recommendations for improvement in methods of practice and service-delivery were discussed. Findings from this section correlate with objective 4 of the study.

Based on objective 5 of the study, section 6 explored the best interest standard. Here, participants expressed their opinions on if the best interest is upheld for child offenders in South Africa and made recommendations for an improved criterion for the determination of the best interest standard.

5.3 BIOGRAPHICAL DATA

The experts with whom interviews were conducted, namely child justice experts, were recruited from a medical, legal, and academic background, as demonstrated below.

² Refer to chapter 1 for research aims and objectives of this study.

TABLE 7: BIOGRAPHICAL DATA OF EXPERTS

	PARTICIPANT	PROFESSION	YEARS OF EXPERIENCE IN CHILD JUSTICE	YEARS OF EXPERIENCE IN CHILDREN WITH PSYCHIATRIC DISORDERS	YEARS OF EXPERIENCE IN CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS	FUNCTION
1	Professor Anne Skelton	Professor of Law & Director for Child Law Centre University of Pretoria	25 years		10 years	Draft of child law and litigation for Centre of Child law
2	Dr P Maharaj	Psychiatrist in forensic unit	10 years	10 years	10 years	Specialised in forensic and child and adolescent psychiatry
3	Ms P Martin	Psychologist	5 years	5 years	5 years	Psychotherapy, criminal capacity, and juvenile forensic assessment
4	Anonymous	Advocate	8 years		8 years	Briefed by attorneys to deal with child offenders with psychiatric disorders
5	Mr M Batley	Probation officer	14-20 years			Contributed to a case at the Centre for child law. Former CEO restorative justice centre
6	Ms M Human	Criminologist Academic	4 years		4 years	Specialise in child justice, criminology curriculum. Voluntary work with abused children in Western Cape.
7	Mr C Willows	Psychologist	36 years	36 years	36 years	Working with children as a psychologist Criminal capacity assessment. The focus is on children 10-14 but also conducts assessments for children 14-18 years of age.
8	Mr B Collins	Probation officer supervisor	10-14 years			Probation officer supervisor
9	Anonymous	Probation officer supervisor	10 years			Assessment of children in conflict with the law for a court in Pretoria
10	Mr S Pillay	Clinical	2-3 years	10 years	2-3 years	Criminal capacity

		Psychologist				assessment for children in conflict with the law. Criminal procedures for serious offences. Assessment on competency to testify in court.
11	Ms E More	Probation officer supervisor	13 years+			Assessment of children in conflict with the law. Assessment of nature of offence and referral for diversion
12	Ms E Webber	Advocate	4 years		1 and half years	Policy development distanced interactions in dealing with children in conflict with the law Specialised field.
13	Anonymous	Clinical psychologist	8 years		4 years	Directly involved with child offenders but not all have disorders. CC assessment.
14	Professor Julia Sloth-Nielsen	Professor of law at the University of Western Cape	30 years			Academic
15	Dr S Omar Teddy Bear Foundation	Clinical director at Teddy Bear Foundation	20 years+			Specialised in child sex offenders. Clinical director
16	Ms E Steenkamp Teddy Bear Foundation	Social worker	15 years		4 years+	Project manager of school programmes for child sex offenders
17	Dr W Duncan	Child Psychiatrist		21 years		Child psychiatrist Outpatient service. Assessment. Diagnoses. Plans for management and treatment.
18	Professor J Barkhuizen	Professor of Criminology and acting Head of Department of Criminology at the University of Limpopo	10 years			Academic and research
19	Professor T Lazarus	Professor of psychology	22 years	22 years	22 years	Clinical and forensic neuropsychologist. Criminal capacity assessment and management for child offenders for schedule 2 and 3 offences and sex

						offenders.
20	Ms C Gould	Senior researcher for crime and justice programme at the Institute for Security Studies Director for Seven passes initiative	10 years			Academic. Management oversight and direction in community violence intervention programme partial care facility.
21	Mr B Viljoen	Clinical Psychologist				Psychologist Criminal capacity assessment and management for child offenders for schedule 2 and 3 offences and sex offenders.
22	Ms J Van Niekerk	Social worker	30 years	30 years		Therapeutic and training dealing with child offenders- and child offenders with psychiatric disorders
23	Ms Chabala	Criminologist and Academic at the University of Limpopo	14 years			Academic
24	Professor G Pretorius	Psychologist, Academic at the University of Johannesburg		37 years		Psychologist Psycho-Legal expertise

It is apparent from the table above that the participants have a wide and diverse field of experience in child justice, legislation, mental health, and child psychiatry and psychology. The experts who participated in the study will be referred to as 'participant', and those participants', who waived their right to anonymity, will be referred to by name.

The participant's responses are presented in narration, verbatim quotations (referenced by the participant's name or participant number for those who waived their right to anonymity), as well as in a discussion. This was done in order to capture the essence and meaning of the expert's views and opinions. The expert's opinions are unedited.

5.4 PSYCHIATRIC DISORDERS AND CRIMINAL BEHAVIOUR

As outlined, participants were asked to express their opinions on aspects pertaining to psychiatric disorders and criminal behaviour in children, which is addressed in section 2. These factors included the definition and categorisation of neurodevelopmental and disruptive, impulse-control, and conduct disorders³ and the influence of psychiatric disorders on criminal behaviour. In addition, participants also voiced their opinions on the severity of psychiatric disorders in relation to the type and seriousness of criminal offences. Findings from this section speak to objective 2 of the study and were henceforth explored.⁴

- **The categorisation and definition of neurodevelopmental and disruptive, impulse-control, and conduct disorders**

➤ *Definition*

Participants were asked, “In your opinion, how would you define a psychiatric disorder”. The reasoning behind asking both legal and mental health child justice practitioners this question was to decipher if all child justice experts have the same or similar understanding of what a psychiatric disorder is, to identify abnormal behaviour in a child who comes into conflict with the law.

The majority of participants (participant 1, 3, 4, 6, 9, 11, 12, 17 & 18) indicated that if a psychiatric disorder was in the DSM-5 (2013), then it is classified as a diagnosable psychiatric disorder, with biological, hormonal, genetic and environmental underlying causes. In addition to using the DSM-5 (2013) as a basis, the participants furthermore identified the manifestation and occurrence of a psychiatric disorder as impaired cognitive, emotional, behavioural, and psychological functionality; which influence the criminal capacity of the child.

These participants furthermore concurred that psychiatric disorders manifest on multiple levels, causing social, emotional, psychological, and physical impairments to wit cognitively, psychologically, behaviourally, socially, and academically, that can lead to harm and maladaptation in a normal society on a multi-dimensional level.

³ Refer to chapter 3, of this study for a detailed discussion on the prevalent psychiatric disorders found in child offenders. Refer to Geoffrey (2016:121) since her findings provided the platform on which the prevalent psychiatric disorders were identified for this study.

⁴ Refer to Chapter 1, for the research aims and objectives of this study.

On the other hand, some participants (participant 2, 10, 13, 17, 21) opinions differed from the view that ODD and CD were psychiatric disorders in that, they regarded disruptive, impulse-control, and conduct disorders, as comorbidities of neurodevelopmental disorders and a result of environmental and psychosocial factors; which cause the child to behave in a defiant and oppositional manner, rather than ODD and CD being a 'pure' psychiatric disorder, with biological or genetic causes. These participants thus acknowledge neurodevelopmental disorders in terms of diagnostic criteria in the DSM-5 (2013) however, disagree that disruptive, impulse-control, and conduct disorders are diagnosable psychiatric disorders.

In terms of the diagnostic criteria for psychiatric disorders, Professor T Lazarus (participant 19) added that the DSM-5 (2013) has discontinued the use of the multi-axial system in diagnosis, as previously used in the DSM-IV (1994). The multi axial-system provided guidance in terms of diagnosis to ensure that adequate attention was granted and documented on a five-axis scale, however, according to research; this system was ineffective and time consuming for practitioners (Kress, Adamson & Paylo, 2017:1). The new manual (DSM-5, 2013), as opposed to the older edition (DSM-IV, 1994), allows practitioners to be mindful of the primary disorder and to take into consideration decreasing or less severe disorders and comorbidities which may affect the child (American Psychiatric Association. 2018:1). The acknowledgement of secondary psychiatric disorders, and/or comorbidities, is an important factor to identify in this study, since research reflects that psychiatric disorders, such as ADHD, LDD, IDD, CD and OD, are comorbidities of each other and therefore children suffering from ADHD, IDD and LD may suffer from comorbid symptoms of ODD and/or CD, and vice versa.⁵ In addition, the acknowledgement of changes to the DSM-5 (2013) is of significance to this study since they influence the way children with psychiatric disorders are diagnosed and subsequently treated.⁶

⁵ Refer to chapter 3, on the diagnostic criteria and literature which reflects co-morbidities present in child offenders suffering from ADHD, LD, IDD, ODD and CD.

⁶ The development and changes in the DSM-5 (2013) are discussed in detail in chapter 3.

➤ **Categorisation**

As a follow-up question, participants were asked, “Do you categorise neurodevelopmental as well as disruptive, impulse-control, and conduct disorders as psychiatric disorders?” This question stemmed from the literature explored in chapter 3 of this study, as well as from research conducted by Geoffrey (2016:135) which outlined that presently disruptive, impulse-control, and conduct disorders are not recognised by all child justice practitioners as psychiatric disorders but rather comorbidities of neurodevelopmental disorders, or as behavioural issues due to environmental factors. This identification indicated that, due to the aforesaid ideology of child justice practitioners; child offenders with psychiatric disorders are not provided with adequate care, attention or granted priority of service since practitioners do not recognise the seriousness of providing treatment to this vulnerable group (Geoffrey, 2016:147-148; Boezaart & Skelton, 2011:18; Breen, 2011:6-7).

The opinions expressed here were divergent. Several participants (participant 1, 3, 6, 7, 11, 13, 15, 16, 20 & 22) concurred that neurodevelopmental and disruptive, impulse-control, and conduct disorders are classified, diagnosable psychiatric disorders, which are identified in the DSM-5 (2013).

“...more than the fact that it is in the DSM [DSM-5, 2013]...if you look at a psychiatric disorder as anything that causes impairment, then ADD, LD and IDD do cause impairment, so if you use that as a criteria then yes [these disorders are psychiatric disorders]” (Anonymous: participant 13).

“...I do agree [ADHD, LD, IDD, ODD and CD are psychiatric disorders] except I think that the label of CD is too easily applied.....” (Ms J Van Niekerk: participant 22).

Although Mr C Willows (participant 7) concurred that neurodevelopmental and disruptive, impulse-control, and conduct disorders are psychiatric disorders, he added:

“It [ADHD, ODD and CD] describes a behaviour. It does not give insights into the nature of the disorder in terms of thoughts and background etc.” (Mr C Willows: participant 7).

The opinion expressed by Mr C Willows (participant 7), implies that although according to the DSM-5 (2013: 59, 60, 460-471), ADHD, ODD and CD are viewed as psychiatric disorders; the diagnostic criteria provided are more descriptive in terms of the behavioural characteristics rather than an insight into the disorder itself. In this respect, this could create confusion for medical practitioners, in terms of treatment, since there are no further details into the disorder, other than the behavioural characteristics provided by the DSM-5 (2013: 59, 470-474).

In addition to the opinions which acknowledged neurodevelopmental and disruptive, impulse-control, and conduct disorders as psychiatric disorders, other participants (participant 2, 10, 13, 15, 17, 19, 21), concurred that neurodevelopmental disorders are regarded as mental disorders but questioned the diagnosis, classification and categorisation of disruptive, impulse-control, and conduct disorders.

“...It’s not a case of they [children suffering from disruptive, impulse-control, and conduct disorders] can’t control their impulse or the urge... it’s more a case of they often choose not to... In my personal opinion, they [children suffering from CD and ODD] form a different category of disorders that require intervention. There are clinical features to it, but it does not equate to having a mental illness” (Dr P Maharaj: participant 2).

“CD...the mere use of the word ‘disorder’ sometimes then the presumption is that the child has a mental illness which means it warrants the same type of care which you would give to a child with IDD or ADHD so sometimes the terminology can create some of the confusion” (Dr P Maharaj: participant 2).

“...I do think there is a disconnect, whether it’s in the definition in the Mental Health Care Act and that is why the mental health practitioners that I’ve dealt with view it like that, I’m not sure, but there is definitely a divide...or two different clarifications between those two [disruptive, impulse-control, and conduct disorders and neurodevelopmental disorders]” (Dr S Omar: participant 15).

“ODD...there is an element of a behavioural disorder, but [it is] clearly an emotional disorder...In the comorbidity [of ODD and CD], there are a lot of psychiatric symptoms...it in itself [ODD and CD] would struggle to

fall into the realm of a purely psychiatric condition..." (Dr W Duncan: participant 17).

"...an impulse disorder in itself is a difficult one to prove, the neurodevelopmental disorder is more hard-wired, and comes from sort of risk involvement or early birth, during birth, prenatal birth process or any kind of exposure to disrupt the development of the child" (Professor T Lazarus: participant 19).

These opinions imply that, although documented in the DSM-5 (2013: 460-471) as psychiatric disorders, the manifestation and emergence of disruptive, impulse-control, and conduct disorders (ODD and CD) are triggered by environmental circumstances, rather than neurodevelopmental disorders, hence they are not recognised as pure psychiatric disorders, such as ADHD, LD and IDD, which are considered to be purely genetic or biological. In the case of ODD and CD, some participants (participant 2, 10, 13, 17, 19 & 21) assumed that the child chooses to behave in a defiant manner rather than the problem behaviour is a result of poor impulse control. The participants (participant 2, 10, 13, 17, 19 & 21) were also of a similar opinion in that, it is exceedingly rare to encounter an individual with a 'pure' case of ODD or CD, without other social-environmental factors such as parental neglect, poor living conditions and socio-economic constraints being present.

It was of significance to the study to ask the aforesaid questions and to have both medical and legal participants' opinions in defining and categorising the psychiatric disorders since these are the professionals who deal with child offenders with psychiatric disorders in the child justice system and require an adequate amount of knowledge of factors which may be influential in terms of causing problem behaviour for children in conflict with the law. The opinions from the medical and legal practitioners were diverse in that some participants (participant 2, 10, 13, 15, 17, 19 & 21) viewed neurodevelopmental disorder, in terms of its definition and categorised it as psychiatric disorder whereas disruptive, impulse-control, and conduct disorders were questionable in terms of categorisation as a psychiatric disorder. In this respect, these participants (participant 2, 10, 13, 15, 17, 19 & 21) believed, ODD and CD, were comorbidities of neurodevelopmental disorders, or a result of environmental factors, rather than being purely psychiatric. Whereas other

participants (participant 1, 3, 4, 6, 9, 11, 12, 17 & 18) viewed both neurodevelopmental and disruptive, impulse-control, and conduct disorders as psychiatric disorders. There was no specific theme which could be identified to indicate if there is a specific preference for medical or legal practitioners and all opinions, from medical and legal practitioners were diverse.

In addition to the previous opinions, Professor T Lazarus (participant 19) and Professor J Sloth-Nielsen (participant 14) highlighted the importance of being cognisant about a child's age in determining the impact of a psychiatric disorder on a child who comes into conflict with the law. In this regard, Professor T Lazarus (participant 19) indicated that it is important to differentiate between children and adolescents with psychiatric disorders, especially in terms of the age of criminal capacity, in accordance with the Child Justice Act.⁷ Professor J Sloth-Nielsen (participant 14) indicated that since the diagnosis of a psychiatric disorder is wide spectrum; and due to the diversity and various contributing factors which may affect the child in terms of psychological, emotional and social development, it is necessary for a specialised referral or expert evidence when determining the criminal capacity of a child who comes into conflict with the law. These opinions are of importance to this study since factors, such as the determination of age will directly impact the child's behaviour, psychological, emotional and cognitive development and with that, the need for specialised services is necessary in order to ensure that the child is dealt with in his best interest and all influential factors are taken into consideration.

Findings indicate that although neurodevelopmental disorders and disruptive, impulse-control, and conduct disorders are diagnosable psychiatric disorders documented in the DSM-5 (2013), opinions from participants, differ with regards to the definition and classification of neurodevelopmental disorders in comparison to disruptive, impulse-control, and conduct disorders.

Stemming from the discussion on the definition and categorisation of ADHD, LD, IDD, ODD and CD; despite the opinions expressed by some of the participants (participant 2, 10, 13, 15, 17, 19 & 21) who disagreed that disruptive, impulse-control, and conduct disorders are psychiatric disorders, it is of significance to

⁷ See the Child Justice Amendment Bill (2018:10), pertaining to the age of criminal capacity for children in conflict with the law.

highlight that chapter 3 of the study⁸ provided a clear description, in accordance with the DSM-5 (2013:461), of the diagnostic criteria and categorisation of neurodevelopmental and disruptive, impulse-control, and conduct disorders. With that said, it is of importance to take into consideration the practical experience and opinions of practitioners in this regard, although it differs from literature in the DSM-5 (2013) since these experts deal with children as well as adults with psychiatric disorders daily and provide a practical, real-life overview of the disorders, rather than just a purely textbook view.

In conclusion to this theme, attention must be drawn to the aim and objectives of this study, which is to recommend a trans-disciplinary approach to deal with child offenders with psychiatric disorders, since concern arose in feedback from the participants who disregarded disruptive, impulse-control, and conduct disorders as psychiatric disorders. Although the opinions which disregard ODD and CD as psychiatric disorders are reflected by only a minority of experts who deal with child offenders with psychiatric disorders, the concern is that if child justice experts cannot agree upon the categorisation of ODD and CD, and share such a wide interpretation of these disorders and their influence on children coming into conflict with the law; such divergent opinions will have a negative impact on the determination of criminal capacity, care, treatment and services.

For example, in terms of the criminal capacity for a child over the 14 years of age, it could be argued that the ideology which does not acknowledge disruptive, impulse-control, and conduct disorders as psychiatric disorders would imply that the child does, in fact, have the criminal capacity to be held liable for his actions. Thus, the influence of the disorder, although taken into consideration, will not be adequate enough to prove a lack of criminal capacity or to further ensure that the child receives the protection and treatment as intended in the Child Justice Act, due to the impairments caused by the disorder on the child's cognitive and conative processing.

Following from the divergent opinions about the definition and categorisation of neurodevelopmental and disruptive, impulse control, and conduct disorders preference of care provided to child offenders with ADHD, IDD, LD in comparison to child offenders with ODD and CD, were explored.

⁸ Refer to chapter 3, on the classification of disruptive, impulse-control, and conduct disorders.

➤ **Preference for services**

This theme focused on the preference of services and care for child offenders with neurodevelopmental disorders, in comparison to child offenders with disruptive, impulse control, and conduct disorders. Factors pertaining to the general services that are available to child offenders with psychiatric disorders will be explored further below.

Before the question was posed, “In your opinion, do you think there is a preference of care and services given to child offenders with ADHD, IDD and LD, in comparison to ODD and CD?”, participants were made aware of the different terms in legislation referring to the diagnosis of a mental illness, as well as the DSM-5 (2013) criteria to make a diagnosis. Namely, the Mental Health Care Act (section 1) stipulates, “...a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis ...” whereas the DSM-5 (2013:467) provides a clear criteria for the diagnoses of a psychiatric disorder.⁹ This information was provided in order to demonstrate that legislation allows for interpretation from the medical practitioner, whereas the DSM-5 (2013) provides a clear criterion for the classification and diagnosis of a psychiatric disorder.

The feedback in this section was divergent:

“I do think that there is a preference [of care] given to children with the LD and IDD [neurodevelopmental disorders] as to the ODD and CD [disruptive, impulse-control, and conduct disorders]” (Dr S Omar: Interview 15).

“...In higher economic levels, I would say that ADHD would be picked up much easier and responded to, so that would take preference over CD [in terms of treatment and preference of care]” (Mr M Batley: participant 5).

“...there is a big grey area in terms of who looks after who [pertaining to who should treat children suffering from disruptive, impulse-control, and conduct disorders] and because resources are so limited, psychiatric

⁹ Refer to chapter 3, for a detailed discussion on the legislation and an interpretation thereof pertaining to children suffering from disruptive, impulse-control, and conduct disorders.

facilities want to work with psychiatric conditions where an outcome can be managed medically [such as ADHD] and managed in relation to the staff that the hospital has..." (Dr W Duncan: participant 17).

"...there is virtually no organisation or institution in the country that deals with, treats takes in and assists adolescents with conduct disorder... nobody wants them because they are out of hand ..." (Ms P Martin: participant 3).

When the participants (participant 3, 5, 15 & 17) were probed on their opinions; as to why there was a preference of care given to children suffering from neurodevelopmental disorders, namely ADHD, IDD and LD, in comparison to the disruptive, impulse-control, and conduct disorders; they indicated that society views neurodevelopmental disorder as something that is beyond the child's control, whereas disruptive, impulse-control, and conduct disorders are viewed as 'criminal' and this group of children choose to behave poorly. In addition to these opinions, Dr W Duncan (participant 17) added that in her previous experience of working as a state psychiatrist; there was a verbal policy which prohibited medical professionals from admitting and treating children suffering from disruptive, impulse-control, and conduct disorders. Children with disruptive, impulse-control, and conduct disorders, such as ODD and CD, would then be referred to the criminal justice system to be dealt with since it was considered that their issues were not from a purely mental health perspective. This verbal policy has since changed, under new hospital management and children suffering from disruptive, impulse-control, and conduct disorders are no longer excluded from receiving treatment at this state facility.

In a contrasting opinion to those expressed above, Dr P Maharaj (participant 2) and Mr C Willows (participant 7) indicated that, they were unaware of how the legislative definition of mental illness, which allowed room for interpretation from medical practitioners, affected the availability of services or care given to children suffering from ODD and CD. Both participants (participant 2 & 7) added that in a professional setting, this definition does not create a priority or preference of care because the children who are referred for care, treatment and rehabilitation are dealt with in terms of legislation, namely, the Mental Health Care Act.

Although several participants (participant 2, 10, 13, 15, 17, 19 & 21) debated the categorisation and treatment of ODD and CD, all participants were of the same opinion that disruptive, impulse-control, and conduct disorders are prevalent in many child offenders. Findings reiterate the high prevalence of child offenders with ODD and CD, and therefore it is essential that preference of care is granted to this vulnerable group, from a holistic perspective; thereby addressing the individual needs of the child and upholding the best interest standard on a case-by-case basis as is intended by the protection granted in the Constitution.

In addition to the opinions expressed pertaining to the preference of care granted to child offenders suffering from ADHD, IDD, LD and ODD and CD; other participants (participant 7, 13 & 18) shared an interesting perspective on understanding children suffering from disruptive, impulse-control, and conduct disorders, in that if a person is symptomatic, they are diagnosed with a personality disorder. Yet it is not the same as saying if a person has a personality disorder, they display these symptoms.

“Is the child oppositional because they have a personality problem or do they have a personality problem because they are oppositional? ... It’s that type of confusion” (Mr C Willows: participant 7).

In terms of this study, if this ideology was applied to children suffering from disruptive, impulse-control, and conduct disorders; in order to provide adequate and effective treatment, one would need to holistically approach the child taking into consideration not just the diagnosis but also the manifested behaviour and the factors which caused the child to behave in that way. According to Mr C Willows (participant 7), children suffering from disruptive, impulse-control, and conduct disorders have an impaired ability, but not an inability; and the decision to behave in an oppositional manner is fundamentally reasoned by the child since he experiences feelings of being picked on, treated unfairly or labelled by society and therefore acts out in frustration. In this regard, as reiterated by participant 7, it is vital to go beyond the behavioural description when assessing and treating this group of children and focus on and address the actual difficulties that the child is experiencing which cause the problem behaviour. Thus, the treatment provided to a child offender suffering from ODD or CD should be case-specific thereby addressing the individual needs of the child.

In the context of providing services and individualised treatment, and the need for child justice experts to acquire an adequate level of expertise relating to child offenders suffering from psychiatric disorders; an example was provided by Ms P Martin (participant 3) of a case where a child offender on the autism spectrum, was misdiagnosed and treated for ADHD. In this case, a psychologist diagnosed and treated a child for ADHD with Ritalin, who was actually suffering from ASD. As explored in chapters 2 and 3 of this study, a child suffering from ADHD may manifest inattentive, hyperactive, impulsive, and disruptive behaviour (DSM-5, 2013: 59, 60). Biologically, this may be due to a poorly developed or impaired frontal lobe and a chemical imbalance of dopamine which regulates concentration, emotional responses, and social interactive behaviour (Duggal & Legg, 2016:1; Afolabi, 2016:1; Vlok, 2016:1). Hence, this would require a medical treatment protocol to create a biochemical balance.

On the other hand, a child suffering from ASD may experience recurrent deficits in social communication, social interaction and stereotypical behaviour and interests (DSM-5, 2013: 31). Although impaired concentration, self-control and poor social skills may be comorbidities of both ADHD and ASD, the causes, symptoms and characteristics of each disorder differ greatly, hence necessitating different need-directed treatment (DSM-5, 2013: 31, 59).

With regard to the treatment of a child with ADHD, Novartis Pharmaceutical Corporation (2017:2-3), the manufacturer of Ritalin outlines that, the typical treatment protocol for a child suffering from ADHD would include medical management with stimulant drugs, such as Ritalin, since this drug provides a balance to the chemical imbalance experienced by the child, in terms of impaired concentration, poor self-control and emotional stability (Novartis Pharmaceutical Corporation, 2017:2-3). Specific to a child suffering from ADHD or ASD, side effects of Ritalin, for example, may exacerbate negative behaviour, namely anxiety, tension, agitation, aggression, and hostility (Novartis Pharmaceutical Corporation, 2017:2-3). Although there are benefits from stimulant drugs, such as Ritalin, and without going into too much detail, an incorrect diagnosis and prescription, such as diagnosing an ASD child as ADHD, may have adverse effects on the child in terms of aggravating the characteristic of the disorder and negatively affect the child on a

neurodevelopmental level, which may result in poorer social interaction, increased anxiety and aggression (Novartis Pharmaceutical Corporation, 2017:2-3; DSM-5, 2013: 31, 59; Duggal & Legg, 2016:1). Thus, this negative behaviour may cause the child to manifest further problem behaviour which could bring him into conflict with the law.

It can be confirmed from the example above that there is a lack of knowledge and skills from child justice practitioners dealing with children in conflict with the law and child offenders suffering from psychiatric disorders. The danger for children suffering from psychiatric disorders is that this group is vulnerable to poor, incorrect treatment, which may exacerbate their condition and increase their risk of criminal behaviour.¹⁰ This identifies the lack of specialised knowledge and the need for up-skilling of child justice experts, who deal this vulnerable group of children.¹¹

It is in this respect that the need for a holistic approach in understanding the complexities and causative factors of the disorder, in order to provide individualised rehabilitation, instead of generic programmes presently used to deal with child offenders suffering from psychiatric disorders, is highlighted (Geoffrey, 2016; 147-148; Boezaart & Skelton, 2011:18; Breen, 2011:6-7). A holistic approach reinforces the aim of this study, which is to develop and make a recommendation for improvement in legislation and methods of practice used to deal with this vulnerable group, from a multi-disciplinary, holistic framework.

In concluding remarks participants (participants 3, 5, 15 & 17) opined that children suffering from psychiatric disorders were a neglected group, who are given less priority and care and are not provided with adequate services and interventions. The overarching feedback from this section reflected that to provide treatment to this vulnerable group of children,¹² child justice practitioners need to focus holistically on all factors that affect the child and cause problem behaviour, and not just on the diagnostic label or the criminal offence committed.

¹⁰ Refer to <https://www.cchrflorida.org/adhd-the-epidemic-of-misdiagnosis-and-overmedication-in-children/> on the effects of misdiagnosing and incorrectly medicating children.

¹¹ Factors pertaining to the services and skills of child justice practitioners will be explored later in this chapter.

¹² Child offenders suffering from psychiatric disorders.

It also is important to acknowledge that participants identified child offenders suffering from the disruptive, impulse-control, and conduct disorders as children in need of care and protection in terms of section 150 of the Children's Act.¹³ This identification reflects the legislative provision, in the South African law, for a group of children who are in a state of physical and/or mental neglect and who manifest behaviour that is challenging for the parent/guardian to control. Thus, although there is legislative provision made for this group of children, the implementation thereof is lacking and rights, pertaining to the availability of services, specifically for children suffering from disruptive, impulse-control, and conduct disorders, are violated. Hence there is some concern over the lack of protection of the best interest standard for this group of children which right is fundamental in the South African human rights arena.

- **Perceptions of the frequency and prevalence of psychiatric disorders in children in conflict with the law**

Following the exploration of the definition, categorisation, and availability of services to child offenders suffering from neurodevelopmental and disruptive, impulse-control, and conduct disorders; participants perceptions on the frequency and prevalence of psychiatric disorders in child offenders were explored. The themes identified in this section included the prevalence of child offenders with psychiatric disorders; the types of psychiatric disorders which are found to affect children in conflict with the law; and the influence of psychiatric disorders on the criminal capacity of a child offender.

- ***The frequency of psychiatric disorders in child offenders***

When asked: "In your expert opinion and based on experience, do you think psychiatric disorders are prevalent in child offenders?" the majority of participants (participants 1, 3, 5, 6, 9, 10, 12, 15, 19 & 22), indicated that many child offenders display abnormal behaviour, which is symptomatic of psychiatric disorder.

"...Worldwide there is at least a 40 per cent incidence of psychiatric disorders and adolescent offenders...Prison inmates reflect higher...almost 80 per cent prevalence of psychiatric disorders"
(Professor T Lazarus: participant 19).

¹³ Refer to chapter 4, on children in need of care and protection.

“...the problem is broader than anticipated...but from feedback from the social workers it sounds as if it [the prevalence of child offenders with psychiatric disorders] is incredibly widespread... and those are just the children that they see” (Ms E Webber: participant 12).

“Yes, I think they [ADHD, ODD and CD] definitely do impact on criminal behaviour because the problem with most of these disorders is that they affect impulse control” (Professor A Skelton: participant 1).

In addition to the aforesaid opinions, which confirm the prevalence of child offenders with psychiatric disorders, participants (8, 12, 15 & 22) indicated that it was difficult to provide a clear estimation of the frequency of child offenders with psychiatric disorders, since there has been a noted decrease in the number of children being assessed over the past few years. This was not due to a decrease in children coming into conflict with the law, but due to a limitation of services, service-providers, and subsequent assessments. Additionally, due to the limited time-frame allowed for assessment, it was often difficult to make a probable diagnosis.

“...Many children fall through the cracks [due to time constraints and a lack of available service-providers] and are not being diagnosed and for me, that is of grave concern...” (Dr S Omar: participant 15).

“...children with LD and mental disabilities, who commit offences... are neglected... [in the child justice system] ...” (Ms J Van Niekerk: participant 22).

“...There are a lot of children [with psychiatric disorders] who are in DCS [Department of Correctional Services] who are undiagnosed...” (Ms E Webber: participant 12).

These opinions confirm that although children, who come into conflict with the law, may suffer from psychiatric disorders which exacerbate problem behaviour, due to limited services, and service-providers these children fall through the cracks of the child justice system, with minimal to no services available to this group of children. This lack of services increases the child's vulnerability in that the influence of the psychiatric disorder is not taken into consideration when dealing with this group of children in the child justice system.

- ***Prevalent psychiatric disorders found in child offenders***

In a follow-up question to the prevalence of psychiatric disorders in children in conflict with the law, participants were asked if ADHD, IDD, LD, ODD and CD were prevalent disorders affecting children in conflict with the law. The majority of participants agreed (participants 1, 2, 3, 5, 6, 7, 9, 10, 13, 17 & 22) and participants (21, 15, 3 & 12) gave feedback as follows:

"... [LD, ODD and CD] ...puts children at a higher risk [for criminal behaviour]" (Mr B Viljoen: participant 21).

"...We have found over the years that a lot of children [child sex offenders] manifest with LD..." (Dr S Omar: participant 15).

"Children with IDD or impulse control disorders [such as ADHD, ODD and CD] are a higher risk [for criminal behaviour]; because they don't pause to think..." (Ms P Martin: participant 3).

"A lot of children with ADHD...there is the element of impulsivity, so that would affect the choices [in terms of coming into conflict with the law and criminal behaviour]" (Dr W Duncan: participant 12).

In addition, some participants (participant 2, 10 & 17) added that psychiatric disorders such as depression, substance abuse disorder and foetal alcohol syndrome were also prevalent, and/or comorbid in child offenders in South Africa.

"...We are seeing that [substance abuse] with greater and greater frequency these days. So, children as young as 10 years of age are using substances like cannabis, alcohol...and opium as well" (Dr P Maharaj: participant 2).

"...If you have a depressed child, in bad circumstances, being told to do something bad [such as substance abuse], and that bad thing will help them fit in...[then the child will participate in undesired behaviour in order to fit in, which could bring him or her into conflict with the law]" (Mr S Pillay: participant 10).

“ADHD would also impact on the likelihood, if untreated, to use substances...and then that takes them down a criminal pathway” (Dr W Duncan: participant 17).

It is of significance to highlight these factors since it was established that depression, foetal alcohol syndrome and substance abuse, are unique to South African children who come into conflict with the law. This is due to the various environmental, socio-economic, and psychological stressors that the child is exposed to, such as child malnutrition, parental neglect and violence (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017:29-34; Paruk & Karim, 2016:548-550). These factors were explored in detail in literature in chapters 2 and 3 of the study.

In addition to the opinions explored thus far from the child justice experts; the majority of medical child justice experts (participant 2, 7, 10, 13, 19 & 21) identified conditions which were not classified in the DSM-5 (2013) but were identified as conditions becoming more frequently identified in children in conflict with the law. This included trauma and brain damage from a trauma-induced disorder, psychosocial problems, academic difficulties, family difficulties, exposure to violence, bullying and a lack of early attachment to the primary caregiver (attachment disorder). These factors were explored in literature in chapters 2 and 3 of this study and will be explored further in this chapter.

In conclusion, it is evident from the findings under this theme that there is a high prevalence of child offenders suffering from ADHD, IDD, LD, ODD, CD, substance abuse disorder and depression, or child offenders who are symptomatic of psychiatric disorders but are undiagnosed. In addition to the psychiatric disorders, attachment disorder was also identified as a prevalent issue facing children who come into conflict with the law.

Since it was established that there is a prevalence of psychiatric disorders in children who come into conflict with the law, the influence of psychiatric disorders on criminal capacity and the correlation between psychiatric disorders and particular criminal offences were explored. The participants' feedback will be explored in the section below.

- **The influence of psychiatric disorders on criminal capacity and the correlation between psychiatric disorders and particular criminal offences**

When asked if psychiatric disorders influenced the criminal capacity of a child in conflict with the law, the majority of participants (participants 1, 3, 7, 9, 10, 14, 12, 15, 16 & 21) concurred that psychiatric disorders are a risk factor which should be taken into consideration, in addition to the influence of the environmental factors, when assessing the child's ability to understand the wrongfulness of his actions (cognitive ability), and the ability to act in accordance with that understanding (conative ability). The participant's feedback was as follows:

"If you are unable to manage your impulses [conative ability], then you are far more likely to engage in behaviour which will be viewed as criminal...and I have definitely come across cases like that [child offenders suffering from psychiatric disorders]" (Professor A Skelton: participant 1).

".....it's not that they [children with IDD, ADHD, ODD and CD] have the capacity and they are bad. Where there is a problem with impulse control [conative ability], there is no space between thought and action... thought and action are one" (Ms P Martin: participant 3).

"...Impulsivity is a typical feature of most of the [psychiatric disorder] conditions ... it is that inability to restrict or restrain one's behaviour [conative ability] ...that is clearly where the problem lies" (Mr C Willows: participant 7).

"...Conduct disorder relates to impulse control, so the test for criminal capacity is whether you know the difference between right and wrong and to act in accordance with that, so if you are not able to control your actions to the same extent then that is relevant to your capacity" (Professor J Sloth Nielsen: participant 14).

"Any disorder will affect criminal capacity..." (Mr S Pillay: participant 10).

"...Unless there is some fairly severe mental disability...we don't often...find evidence with a failure to distinguish between right and wrong but it's really in the acting in accordance with that appreciation [conative

ability] *that those particular types of disorders are significant*" (Mr C Willows: participant 7).

Participants (participant 1, 3, 7, 9, 10, 14, 12, 15, 16 & 21) expressed that psychiatric disorders influence the child's criminal capacity since psychiatric disorders directly affect the cognitive, but more so the conative functioning. This impaired conative ability was reflected in children suffering ADHD, ODD and CD, and will affect the child in terms of his ability to demonstrate self-control and self-restraint. The inability or impaired ability in this regard in-turn affects the child's ability to reason, perceive information, and furthermore choose between a right and wrong action.

Dr W Duncan (participant 17) added that, in terms of the influence of ODD and CD on the child's criminal capacity, some children can be vindictive, cold and are aware of their actions. The sub-category of CD, which includes callous and unemotional traits is the disorder which ought to be given attention, since untreated, this type of CD can develop into ASPD (DSM-5, 2013: 470-474). Dr W Duncan (participant 17) was of the opinion that this group of children often have criminal capacity and these children choose to behave in a defiant and oppositional manner. This opinion was similar to that indicated by the various medical professionals, who did not view CD as a psychiatric disorder but rather as a choice and a description of defiant behaviour. This feedback, from Dr W Duncan (participant 17), provided insight in terms of why this disorder may not be categorised as a psychiatric disorder and may not affect the criminal capacity since children suffering from a severe case of CD are aware of their actions, and choose to behave in a defiant manner (DSM-5, 2013:470-471).¹⁴

In concluding, Dr W Duncan (participant 17) reinforced that children are often victims of their circumstance; each child is unique and therefore needs to be addressed in an individualised, case-specific manner taking into consideration the environmental and biological factors which influence the child.

It is evident from the findings in this section that, the majority of the child justice experts were of the opinion that psychiatric disorders influence criminal behaviour and will have an impact on the criminal capacity of the child. The varied opinions

¹⁴ Refer specifically to DSM-5 (2013: 470, 471) regarding the severity of conduct disorder.

regarding the criminal capacity of children suffering from severe CD, which is substantiated by the DSM-5 (2013:470-471) must be acknowledged since this group of children, are considered to be aware of their actions and have the ability to rationalise in the decision-making process, in comparison to children suffering from ADHD, who experience impulsivity and poor self-control (DSM-5, 2013: 59). This is of particular significance to this study since CD was identified as a prevalent disorder affecting child offenders and although experts are of the opinion that these children have criminal capacity to be held liable for their actions, cognitively and conatively; these children are victims of a system failure and act-out as a result of environmental, societal and psychological issues. This ideology does not excuse the disruptive or defiant behaviour, however, it is vital that in order to treat a child offender suffering from a severe case of CD, one needs to take a holistic approach in addressing the familial, environmental, societal, scholastic, psychological and emotional needs of the child to curb the pre-disposing factors which caused the child to begin on a path of criminal behaviour.

- *The correlation between psychiatric disorders, type of criminal offence and severity of the crime*

The final question explored under the theme of psychiatric disorders and criminal behaviour focused on the correlation between psychiatric disorders and criminal offences. Exploring child justice experts' opinions pertaining to the correlation between psychiatric disorders and criminal behaviour is of significance to this study since literature explored in chapter 3 outlined the specific behavioural characteristics of a child suffering from ADHD, ODD or CD, which can be linked to problem behaviour (DSM-5, 2013). In addition, section 6 of the Child Justice Act provides a clear outline of scheduled offences in terms of categorising the severity of the criminal act. Literature discussed earlier in this study further substantiated that there is a correlation between the type of disorder and criminal offence as well as the severity of the disorder and severity of the criminal offence (Lundström et al, 2014:1; Alley & Cooke, 2016: 4; Selinus et al, 2015; Mordre et al, 2011:1).

In cognisance of the literature explored, which points to the distinct behavioural patterns of children suffering from ADHD, ODD and CD explored in chapter 3 of this

study,¹⁵ participants were asked their opinion on the correlation between psychiatric disorders and specific crimes.

Although research substantiated the correlation between psychiatric disorders and the schedule of criminal offences, some participants (participants 2, 4, 5, 6, 9 & 10) believed one could not link or correlate psychiatric disorders with particular offences.

Other participants (participants 3, 17, 18 & 20) believed children suffering from neurodevelopmental disorders, such as ADHD, LD and IDD were at risk of committing attention seeking, minor offences which bring them into conflict with the law.

“...People with...IDD are more likely to be duped into doing something like carrying a stolen item for somebody just because they are so plausible [sic]” (Ms P Martin: participant).

“...if a child has IDD and coupled with that is impulsivity from ADHD and struggles with understanding boundaries of society...yes, there would be hideous offences which can arise from that...” (Dr W Duncan: participant 17).

On the other hand, opinions from four participants (participants 1, 3, 12 & 15) outlined that children suffering from disruptive, impulse-control, and conduct disorders were more likely to become involved in violent, aggressive, defiant criminal offences.

“...[Their] [children suffering from disruptive, impulse-control, and conduct disorders] behaviour is likely to get them charged with a crime because they harm other people or break other things ... although they may not be intentionally aiming to commit a crime...CD is more likely to result in violent acts towards other people and property” (Professor A Skelton: participant: 1).

“The child with severe CD, the child per definition may act out in an anti-social way, breaking windows, when confronted becomes extremely aggressive, and acts in accordance with aggression, is unable per se to

¹⁵ See chapter 3, on the diagnostic criteria used to diagnose children with neurodevelopmental disorders.

restrain themselves, because of that... they are unable to restrain, they act out in accordance with their diagnosis, they act out in an anti-social manner, they are manipulative, they are aggressive, they lie, they steal and those are the crimes that they are generally charged with: malicious damage to property, assault, attempted murder" (Dr S Omar: participant 15).

"...CD and ODD you could have anything... it's that interpersonal violence...it could be rape, it could be murder, it could be ... aggravated assault, it could be housebreaking...any number of things" (Ms P Martin: participant: 3).

"...Definitely for CD's it's more violent...children who have a range of CDs... such as children raping siblings, stabbing teachers, threatening other children and adults with knives" (Ms E Webber: participant 12).

"...We have found over the years that a lot of children [child sex offenders] manifest with IDD and LD..." (Dr S Omar: participant 15).

Dr S Omar (participant 15) provided a different opinion to that of the aforementioned participants who outlined that there is no correlation between psychiatric disorders and criminal behaviour. Participants (participants 1, 3, 12 & 15) who 'support' the correlation between psychiatric disorders and particular criminal offences indicated that children suffering from neurodevelopment disorders are more likely to become involved in less serious, schedule 1 related criminal offences whereas children suffering from disruptive, impulse-control, and conduct disorders, are likely to become involved in more serious, schedule 3 related offences. Dr S Omar (participant 15) was of the opinion that in their experience at the Teddy Bear Foundation, child sex offenders often exhibited symptoms of LD and IDD. This implies that the seriousness of an offence is causally linked to the characteristics and impairments caused by a particular psychiatric disorder.

The general feedback from participants in this section, who commented that there was a correlation between psychiatric disorders and criminal behaviour, was that it is important to take into consideration the child's environmental factors, social context and co-morbidities which affect the behaviour, rather than purely the influence of the disorder itself. This holistic approach is of importance since children mimic the

behaviour and the seriousness of offences may be as a result of not only the influence of the disorder but also of learned behaviour from the environment (Paniagua, 2018:4; Siegel, 2016:321; Demuthova & Bucik, 2013:18).

In addition to the aforesaid factor, it was also stated (Mr C Willows: participant 7) that it is important to consider the frequency of behaviour, such as the level of empathy, rather than the label of a psychiatric disorder, since research (Posick, Rocque & Rafter, 2013:1) substantiates that lower levels of empathy often correlate with more serious criminal offences. This may also be applied to children suffering from a severe type of CD, since literature explored in chapter 3 of this study, indicated that this group of children lack empathy and therefore commit more serious criminal offences.¹⁶

A recurrent factor which emerged in all themes touched on the influence of not only the psychiatric disorder but also the environment and socio-economic factors, i.e. holistic influential factors. This identification is of significance to this study and substantiates the aim which is to recommend that child offenders suffering from psychiatric disorders are dealt with from a multi-disciplinary, trans-disciplinary, holistic perspective, instead of the single-dimensional approach currently used to deal with this vulnerable group (Human, 2015:112; Geoffrey, 2016:167-171).

The findings from this section met objective 2 of this study. Although the opinions differed on the classification and identification of disruptive, impulse-control, and conduct disorders, in terms of it being psychiatric, the overarching feedback indicated that this group of children need to be dealt with holistically in order to treat, prevent and reduce criminal behaviour. This recommendation applies to all child offenders, for those suffering from psychiatric disorders, as well as for those who do not have psychiatric disorders. A holistic, multi-disciplinary approach would address the biological, psychological, environmental, and social factors which affect the child thereby addressing the causative and pre-disposing factors which caused the child to become involved in criminal behaviour.

In addition to the psychiatric disorders highlighted as most prevalent in child offenders, namely ADHD, LD, IDD, ODD and CD; substance abuse disorder,

¹⁶ Refer to chapter 3, for discussion on children suffering from CD.

depression and attachment disorder were also highlighted as prevalent. It is of importance to note that, the additional disorders identified by the child justice experts were considered to be unique to an African context, since many children residing in African countries experience poor socio-economic circumstances, poor living conditions, child malnutrition, exposure to violence and substance abuse, to name a few. This opinion was also substantiated in literature explored in chapter 2 and 3 of this study which identified the risk factors for child offenders in African countries¹⁷ (Anon, 2017:1; Bella et al, 2010:1; Atilola et al, 2015:2; Olashore et al, 2016; Heita, 2015; 1; Winterdyk, 2013:1; Olashore et al, 2017:1; Cortina et al, 2012: 276-281; Ntsabo, 2018:1; Van Der Merwe, 2015:1).

In cognisance of the aforesaid factors that are unique to child offenders suffering from psychiatric disorders and stemming from the discussion on the influence of psychiatric disorders and criminal behaviour, in the section to follow, causative factors influencing the development of psychiatric disorders and criminal behaviour will be explored.

5.5. CAUSATIVE FACTORS

Under causative factors, two themes were explored. The first theme focused on the biological, psychological, social, and environmental factors influencing the development of psychiatric disorders and criminal behaviour. These factors were selected, as literature explored in chapter 2 and 3 of this study theoretically substantiated prevalent causative factors influencing the development of psychiatric disorders and criminal behaviour in children who come into conflict with the law.¹⁸ Findings from this section speak to objective 3 of this study which aimed to explore the causative factors which affect the child in terms of psychiatric disorder and criminal behaviour development.

In addition to the influence of these four factors, on the development of psychiatric disorders and criminal behaviour, the second theme, focused on if and how these

¹⁷ Refer to chapter 2, and chapter 3, for a detailed discussion on the causative factors influencing a child offender in the selected African countries of comparison.

¹⁸ Refer to chapter 2, and chapter 3 for a detailed discussion on the causative factors influencing a child offender in the select African countries.

four factors, affect the child's brain development in relation to the five developmental domains in the Child Justice Act (section 11).¹⁹

Being cognisant of these factors is important since they directly influence the cognitive, moral, emotional, social, and psychological developmental domains under section 11 of the Child Justice Act which is used to assess criminal capacity. The consideration of these factors, in terms of how they affect the child's cognitive and conative function, is vital to determine the child's ability to appreciate his actions, to act in accordance with that appreciation and furthermore the treatment required.²⁰

- ***The influence of biological, psychological, social, and environmental factors on the development of psychiatric disorders and criminal behaviour***

When asked if biological, psychological, social and environmental factors influence the development of psychiatric disorders and criminal behaviour, the majority of participants (participant 3, 6, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20 & 21) agreed that all factors, in tandem, contribute to the development of psychiatric disorders and criminal behaviour.

"...We are multifaceted, and it is nature versus nurture, we do not exist in a vacuum. ...We need to appreciate and recognise that it is not a one size fits all... we need to recognise the uniqueness of each [influential factor] and consider the socialisation, their experiences, what they make of their experiences, the risk factors and protective factors..." (Dr S Omar: participant 15).

"...the family background, the family violence, the family substance abuse, poverty... there are so many contributing factors, but the family is the core" (Anonymous: participant 9).

"...if one goes right back to the vulnerability that starts in utero, you will have the biological, genetic maternal milieu for the child, you also have the mothers emotional stress, nutritional stress...that's directly

¹⁹ Refer to section 11(3) of the Child Justice Act, for the five developmental domains used to assess criminal capacity for children in conflict with the law.

²⁰ Refer to chapter 3, pertaining to criminal capacity and the influential factors pre-disposing children with psychiatric disorders to come into conflict with the law.

determined by social community economic factors. Once the child is born, the attachment will be influenced by all of the above...and it goes further because at each point these factors will influence the child... (Dr W Duncan: participant 17).

"...It depends entirely on the circumstances... there can be times when the biological and environmental factors come together in a particularly awful kind of way...For example, children who have had a poor attachment, poor impulse control and also exposure to abuse and poor home environments. You are going to find children who are more difficult for adults to handle, they might not be loveable, and because they are difficult and because they are hard to handle their attachment is harder. These kinds of children have a harder time in the family, they are more likely to be punished and experience corporal punishment..." (Ms C Gould: participant 20).

"...I do think biological and psychological, in terms of attachment and child raising style, parenting styles...those do seem to come across...not excluding the other factors [namely, social and environmental], but those factors looking at the environments that some of the children come from [plays a strong role]" (Mr B Viljoen: participant 21).

The findings from this section indicate that there are multiple causative factors which influence the development of psychiatric disorders and criminal behaviour in children. Brief examples of the following causative factors, which are found to specifically affect the behaviour of child offenders with psychiatric disorders include, but are not limited to, the biological factors which occur prenatally as well as in early developmental stages of the child's life. The environment and social factors, namely the child's family, living environment, living conditions and school peers, were identified as external factors which influence the development of criminal behaviour. Psychological factors, which were identified as internal factors, include the familial and social bonds and attachment, exposure to stress and trauma, and living experiences, in conjunction with a poor living environment, was found to increase the risk of delinquency in children. These factors were not only identified from the child justice experts but were also outlined in literature explored in chapter 3 of this

study.²¹ A combination of these factors in tandem influence problem behaviour in children which causes them to conflict with the law.

Since this study focuses on child offenders in the select African countries²² it is of relevance to reiterate that, many children reared in South African rural areas are exposed to poor living conditions, substance abuse, child molestation, violence and child malnutrition (Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550). These factors not only influence the way the child will behave but also the learning cues, psychological processing, and interpretation of situations since this undesirable behaviour is learned as desirable and a norm (Paniagua, 2018:4; Siegel, 2016:321; Demuthova & Bucik, 2013:18).

Professor T Lazarus (participant 19) shared a similar opinion to most of the participants in that there are multiple causative factors which influence problem behaviour for child offenders with psychiatric disorders. However, in addition to this, he added:

“...There has to be some kind of paradigm shift of looking into what are the sociocultural factors and to what extent are those changing the paradigms of normative behaviour, what is acceptable and what is not”
(Professor T Lazarus: participant 19).

Professor T Lazarus (participant 19) elaborated that, South African children who come into conflict with the law are not always fully integrated into urban areas and therefore, in certain cases, do not understand the expected and desired behaviour of an urban society. Thus, the child may not fully appreciate the wrongfulness of their behaviour in terms of it being criminal, although interpreted by society as undesired and criminal. In cognisance of this, it is important to take the context, socio-cultural factors and living environment into consideration when determining factors which influence criminal behaviour. Furthermore, research substantiates that since these factors will have a direct impact on pre-disposing the child to criminal behaviour, consideration must also be granted to how the socio-cultural and living environmental

²¹ Refer to chapter 2, this study for biological, psychological, environmental, and social factors which influence the child.

²² Refer to chapter 2, and chapter 3, for a detailed discussion of the causative factors influencing a child offender in the select African countries.

factors impact criminal capacity and the best interest of the child (Paniagua, 2018:4; Siegel, 2016:321; Demuthova & Bucik, 2013:18).

Thus, the decision-making process in dealing with a child offender in the criminal justice system should not be approached from a purely psychological perspective, which only factors in the moral, psychological, cognitive, and emotional development²³ but rather a holistic perspective which includes a combination of the aforesaid factors as well as the socio-cultural and environmental factors.

In respect to the opinion which outlines the importance of integration from rural to urban areas, for South African children; or the difficulties thereof in terms of being a causative factor which influences criminal behaviour, Professor T Lazarus (participant 19) furthermore added:

“...the social learning theories of Bandura suggests that one needs to have a model, a role model and imprinting which happens in the first two years of life will take on the context and behaviour of that...I am not saying that these children are totally indiscriminate but that period where critical development takes place, where the child is able to disseminate what is acceptable and not acceptable happens in the first two years of life and if the child grows up in a context where there is that kind of behaviour which is undesirable...there is a greater likelihood that they will absorb that behaviour and replicate it...” (Professor T Lazarus: participant 19).

“...We need to develop a model that is more applied to the South African context and of course involving various types of living circumstances, from deep rural, rural, peri-urban, urban...allow for that transition” (Professor T Lazarus: participant 19).

The feedback, from Professor T Lazarus (participant 19) is of significance to the aim and objectives of this study since he draws a clear distinction between environmental and socio-economic factors which affect South African children. The opinion implies that since behaviour is learned, children who are exposed to violence and substance abuse as a remedy in stressful or aggravating situations, grow and learn to handle stress with a violent or substance abuse response. It is therefore vital to understand

²³ Refer to section 11 of the Child Justice Act.

the demographical, socio-cultural as well as the environmental factors, in conjunction with the influence this has on the psychological and cognitive development of South African child offenders.

Since the focus of this study explores the factors pertaining to psychiatric disorders in child offenders, it is of significance to highlight that according to research (South African College of Applied Psychology, 2018:1) psychiatric disorders, such as ADHD, depression, ODD and CD are not always recognised as actual mental health issues in the African context but are rather considered as problem or naughty behaviour manifested by the child (South African College of Applied Psychology, 2018:1). "...there is often an absence of physical symptoms with mental illness, it is considered 'not real', a figment of the imagination." (South African College of Applied Psychology, 2018:1).

The lack of attention granted to adopt a holistic approach which influences South African children who come into conflict with the law, in the child justice system, is of importance since as demonstrated above, it negatively affects this vulnerable group of children.

In addition to the influence of the biological, psychological, social and environmental factors influencing the development of psychiatric disorders and criminal behaviour, participants were also asked if, and how these factors influenced the child's brain development and furthermore if and how this would influence the five developmental domains used to assess the criminal capacity (Child Justice Act, section 11). This question was asked because literature substantiates that the aforementioned causative factors which influence the development of criminal behaviour are also found to affect brain development, thus, directly impacting on the child's cognitive and conative abilities, namely his criminal capacity (Neumann, 2015:01; Freitas-Silva & Ortega, 2016:1; Mkhize, 2016:1; Vital Brito, 2018:1; McAloon, 2014:1; Afolabi, 2016:1; Vlok, 2016:1; Shroff, 2016:1; Rudo-Hutt et al, 2011:320).²⁴ The feedback from this question will be explored in the section below.

- ***The influence of biological, psychological, social, and environmental factors on brain development***

²⁴ Refer to chapter 2 and chapter 3 for a detailed discussion on the causative factors influencing a child offender in the select African countries.

Following the factors that influence the development of psychiatric disorders and criminal behaviour, participants were asked for their opinion whether biological, psychological, social, and environmental affected the child's brain development and if this had an impact on the five developmental domains used to assess criminal capacity (Child Justice Act, section 11). The findings from this section speak to objective 2 of this study.

The majority of participants (participants 1, 2, 3, 5, 6, 7, 9, 10, 12, 14, 15, 16, 19, 21, 22 & 24) agreed that the aforesaid factors affect the child's brain development, which in turn would influence the cognitive and conative functioning; therefore, directly affecting the five developmental domains used to assess criminal capacity.

"...Each developmental domain needs to be individually and independently assessed to establish the child's criminal capacity and his involvement in the conflict with the law. The final decision should not be made based on 1 particular domain but rather on an integration of all five domains..." (Professor T Lazarus: participant 19).

"a child in a calm moment may be able to say yes... such and such is wrong and won't do that but once you place the child in a demanding situation where they are scared, angry or influenced by older children, suddenly that capacity disappears because the influence of the child is greater. In each area, one can say the child has social development but then in a particular situation behave very badly...so the same would go in other areas as well...a lot goes into context in which something happens" (Mr C Willows: participant 7).

"...emotional level, if there is a biological aspect, strong family history of personality disorder...where there is a lack of empathy ...that will definitely affect the emotional development, and that's where you start seeing that stunting, lack of accountability, lack of responsibility, lack of remorse..." (Mr B Viljoen: participant 21).

"Social development, you would find limited friends, people being objects and being used in that regard...you will see that with ...conduct disorder, in an aspect where there are no meaningful relationships, most relationships are superficial..." (Mr B Viljoen: participant 21).

The feedback from this section outlines that, individual factors within the biological, environmental, psychological, and social factors all influence the brain development of the child, which in turn has a direct influence on the cognitive and conative functioning of children in conflict with the law.

In addition to the aforementioned opinions, Ms M Human (participant 6) shared similar opinions on how violence and abuse lead to toxic stress and how this affects brain development, mood and behaviour; which could result in a psychiatric disorder.

“...Toxic stress in itself compromises the brain’s architecture due to early life adversities in a child’s life. This physically damages the brain which makes learning extremely difficult. Children who have poor academics have a high risk of becoming involved in disruptive or delinquent behaviour. This is not due to their intellect but rather due to labelling and a lack of support from parents and teachers, which causes them to seek acceptance with the wrong company” (Ms M Human: participant 6).

The opinion expressed by Ms M Human (participant 6) is of particular significance to this study since children residing in the selected African countries are exposed to extreme environmental stressors which negatively impact the psychological, emotional and social development of the child which may contribute to problem behaviour, and the child coming into conflict with the law.

Opinions expressed by Ms P Martin (participant 3) were also of significance to this study since the theoretical underpinnings in chapter 2, confirmed the correlation between hormonal imbalance, stressors in the environment and the risk this causes for an adolescent coming into conflict with the law.

“...The development of the brain is affected by those things [biological, psychological, social and environmental] ... and the brain’s capacity, so your genetic predisposition influences how much and in what way those things [affect the child]. It is the nature/ nurture debate. It is both an influence of nature as well as nurture which influences the child and brain development...” (Ms P Martin: participant 3).

“...It is exacerbated by adolescents and the hormonal instability or the hormonal influx change during that period and the partially developed brain” (Ms P Martin: participant 3).

The opinions expressed by Ms M Human (participant 6) and Ms P Martin (participant 3) imply that, in dealing with a child, one needs to be cognisant of the multifactorial influences which the child is exposed to in order to determine the factors which pre-disposed the child to problem behaviour which caused the child to come into conflict with the law.

Professor T Lazarus (participant 19) provided valuable insight to this question by indicating that, in certain instances children lack the ability to reason right from wrong because certain misdemeanours are not considered as wrongful behaviour since it is out of their societal context, namely growing up in a rural environment and the transition into urbanised society. In this light, Professor T Lazarus (participant 19) indicated that, we need to determine to what extent were these wrongdoings committed and to what extent do these children understand the measure of their wrongdoing within this context of right from wrong, and then display behaviour that shows that they actually do understand right from wrong.

The findings from this section met objective 2 of the study which focused on causative factors, and the influence thereof on brain development, psychiatric disorders, and criminal behaviour in children. Since literature and findings, as outlined above substantiate that multiple factors influence brain development, psychiatric disorders, and criminal behaviour this enforces the seriousness of adopting a trans-disciplinary, comprehensive approach when dealing with child offenders suffering from psychiatric disorders. Findings from this section not only meet the corresponding objective, namely objective 2 but also reinforce the aim of this study which is to recommend an improved framework which can be used to deal with child offenders suffering from psychiatric disorders, from a multi-dimensional and trans-disciplinary approach. In the section to follow, child legislation will be explored in terms of its adequacy and recommendations are made for child offenders with psychiatric disorders.

5.6 CHILD JUSTICE LEGISLATION

This section focuses on the adequacy of child justice legislation used to deal with child offenders with psychiatric disorders. Three primary themes were identified under the analysis of child justice legislation and child justice practitioners; namely, the adequacy of the current child justice legislation and methods of practice; the adequacy of professionals in the child justice process and overall recommendations for improvement. The outcomes of section 4 were in line with objectives 1 and 5 of this study. The adequacy of the child justice legislation and recommendations for practice will be explored under one theme and the adequacy of child justice professionals used to deal with child offenders with psychiatric disorders will be addressed under a second theme.

- ***The adequacy of and recommendations for child justice legislation used to deal with child offenders with psychiatric disorders***

Before delving into the participant's opinions on the adequacy of the child justice legislation, it is of relevance to provide a brief overview of the child justice legislation explored in this study. In the contents of chapter 4, a detailed discussion on the present child justice legislation used to deal with child offenders with psychiatric disorders, namely the Child Justice Act, Children's Act, Criminal Procedure Act, and the Mental Health Care Act²⁵ was presented. The document analysis, in chapter 4, explored international conventions pertaining to the rights of the child, the rights of children in conflict with the law, and persons suffering from mental illnesses and legal proceedings for dealing with child offenders with psychiatric disorders. These aspects focused on African countries, such as Namibia, Botswana, Nigeria, and South Africa. Against this framework and in cognisance of legislation, child justice practitioners were asked their opinion pertaining to the adequacy of the current legislative framework and procedures used to deal with child offenders with psychiatric disorders.²⁶

²⁵ Refer to chapter 4, for legislative comparative analysis on child justice legislation in the select African countries.

²⁶ It must be acknowledged that, at the time of the data collection process in this study, the legislative amendments made and documented in the Child Justice Amendment Bill (2018) and the Criminal Procedure Amendment Bill (2017) was not public knowledge. The feedback

In cognisance of the briefly mentioned child justice legislation, participants were asked, if, in their expert opinion, the present child justice legislation used to deal with child offenders with psychiatric disorders was adequate in holistically dealing with this vulnerable group.

The majority of participants (participant 1, 2, 3, 5, 6, 10, 11, 15, 18, 22 & 24) indicated that the legislation and methods of practice, used to deal with child offenders with psychiatric disorders, was inadequate, left to interpretation and did not uphold the child's best interests.²⁷

The participants' comments and opinions follow hereunder:

- Legislation and policy

"...legislation is not holistic in assessing the child..." (Ms J Van Niekerk: participant 22).

"...There is a need for a specialised policy that deals directly with these children..." (Ms E Webber: participant 12).

"...In terms of aligning the CJA with the mental health care act we are still working in silence, there is no synergy..." (Ms E More: participant 11).

"The Mental Health Care Act also falls very short in addressing children in managing children with psychiatric disorders" (Dr W Duncan: participant 17).

Legislative discrepancies highlighted by the participants identified that child justice legislation needs to be holistic, specific, and specialised to factors in the needs of this vulnerable group since presently child offenders with psychiatric disorders are dealt with under general legislation; namely the Child Justice Act, and the Mental Health Care Act and Criminal Procedure Act. The latter two bodies of legislation are bodies of legislation not developed to deal with a child and therefore do not factor-in the needs of children.

²⁷ from participants therefore does not take into consideration these changes and developments.
Factors and recommendations pertaining to the best interest standard will be addressed further in this chapter.

Further to these opinions, concern was also expressed by participants (participant 2, 3, 10, 11, 22 & 24) pertaining to the terminology in the Mental Health Care Act for persons suffering from severe profound disorders and IDD; which does not cover a broad range of other disorders. The terminology used in section 1 of the Mental Health Care Act is legal, generalised terminology which is inadequate and broad and lacks specification regarding children suffering from mental health issues, who conflict with the law.

This concern is similar to the argument made in chapter 3 and 4, in respect to section 77 of the Criminal Procedure Act, which has changed terminologies of a person suffering from psychiatric disorders, from 'mental defect' to 'persons suffering from 'intellectual disabilities'.²⁸ The issue is that legislative terminology; such as the reclassification of a person suffering from a mental defect to intellectual disability (Criminal Procedure Act Bill, 2017), is inadequate since this is a general term. Furthermore, as explored in chapter 3 of this study,²⁹ the definition of intellectual disability is not broad enough to cater to or include all persons suffering from psychiatric disorders. The question arises here is, should a psychiatric disorder, such as ADHD, ODD and CD be identified in a child who comes into conflict with the law, does the child fit the criteria to fall within the spectrum of 'intellectual disability' in the pure definition in order to be protected under section 77 of the Criminal Procedure Act? It is the researchers' opinion that, this legislative inaccuracy is inadequate, limited and does not cater for all psychiatric disorders; which will have negative consequences for a child offender in the child justice system.

Due to these legislative ambiguities, such as a lack of clear definition in terminologies, child justice practitioners are left to their own interpretation and therefore children who come into conflict with the law are not dealt with against a standardised criterion. This not only creates confusion for child justice practitioners but also negatively affects the child since each child will be assessed differently.

²⁸ Refer to chapter 3, and chapter 4, for a detailed discussion of the changes made in the Criminal Procedure Act pertaining to persons suffering from psychiatric disorders, who come into conflict with the law.

²⁹ Refer to chapter 3, pertaining to the definition of terminologies used to define intellectual disability.

In addition to the need for clarity in legislation, Dr P Maharaj (participant 2) indicated that, according to section 47(b) and 52(a) of the Child Justice Act, in order for a child offender, who lacks criminal capacity, to be diverted he needs to acknowledge his criminal act and have criminal responsibility and capacity. The inadequacies of the aforesaid sections were explored in chapter 4 of this study and highlighted the confusion that this creates for child justice practitioners since in this case, it is the duty of the state to then prove that the child does, in fact, have criminal capacity before a referral for diversion can take place. Amendments, in the Child Justice Amendment Bill (2018) addressed the inadequacies of sections 47(b) and 52(a) and it is now not the responsibility of the prosecuting officer to determine the child's understanding of responsibility and to refer for diversion, without mandatory assessment of criminal capacity.

These recommendations are of significance to this study since they reinforce the need for individualisation in terms of the legislative approach and the need for a multi-disciplinary approach which encompasses all factors pertaining to child offenders with psychiatric disorders. In addition to the aforementioned legislative ambiguities, participants identified issues pertaining to criminal capacity in terms of the low age of criminal capacity and issues regarding criminal capacity assessment.

- **Criminal capacity**

- **Age**

“...we are under a lot of pressure from them ...UN Committee on Rights of the Child to peg our level of criminal capacity to 14 [years of age] ...I don't think that increasing the age of criminal capacity to 12 is doing enough...” (Ms J Van Niekerk: participant 22).

In terms of the criminal capacity of the child, the previously mentioned feedback makes a clear distinction on the minimum age of criminal capacity, which although increased from 10 to 12 years of age (Child Justice Amendment Bill), is still inadequate. This is because an increase in age of criminal capacity is not in-line with the international treaties.

➤ **Assessment**

“...when you talk about the 5 developmental domains when they talk about cognitive, moral, and emotional... that is essentially psychological...How can you evaluate the development of the child, if you rely solely upon an unreliable guardian and the child its self?” (Dr P Maharaj: participant 2).

“...for me it’s about getting as much diversity of information, so in the end, my opinion is based on a number of different sources” (Mr S Pillay: participant 10).

“.....the assessment process was costed at requiring half an hour of professional probation time... which is totally unrealistic... “(Ms J Van Niekerk: participant 22).

“I think that it can be quite difficult, when there is a lack of standardisation, norms and standards then it leads to inequity... which is a problem. That means that the same child depending on which hospital they might have visited will be subjected to a very different set of procedures...I think that it’s important for there to be some consensus” (Mr S Pillay: participant 10).

“...Less of a divide [in terms of time] occurring between the assessment and the treatment...the cases are seen faster than they are currently...and more of standardisation and clear guidelines in terms of what to assess and how to assess...” (Mr B Viljoen: participant 21).

“With the work we do, we try to have a holistic and a multi-disciplinary approach to it, with a psychiatrist, psychologist, occupational therapist and social worker being involved...but I know that other facilities do not necessarily work in that way” (Mr B Viljoen: participant 21).

“...These are quite labour intensive and time-consuming assessments, but also very important assessments... research shows that the earlier you intervene by addressing little problems, the more likely you are to change the trajectory of these children...” (Mr B Viljoen: participant 21).

In addition to highlighting the legislative inadequacy of the minimum age of criminal capacity, issues pertaining to the criteria used to assess the child in order to determine criminal capacity were highlighted as an area of concern. Participants (participant 7, 10, 17 & 21) emphasised the lack of standardisation in psychological assessment, and opined that, although the Act does not specify or provide a set of criteria for child offender assessment, each practitioner is left to their own devices to ensure that the best practice is met in the assessment and the concluding report. In this respect, each child justice practitioner is left to interpretation and their own devices to create methodology and structure.

Recommendations for practical improvements and clarity in the Children's Act, Child Justice Act, Criminal Procedure Act and Mental Health Care Act, in the afore-identified regard, which does not leave room for interpretation from practitioners but rather provides clear specifications to create standardisation in terms of assessment criteria and protocol, terminologies and specific responsibilities for each child justice practitioner, are necessary. In this regard, the recommendations were that, to create a form of standardisation in the interim, medical practitioners should adopt a similar assessment style by conducting physical examinations, psychological assessment, IQ testing, emotional evaluation, occupational therapy assessment, evaluation of reports from school and parents. This triangulation method allows for comparative analysis of the information and for a holistic perspective which will ensure that all areas influencing the child are adequately assessed.

In addition, participants (participant 1, 3, 10, 11 & 22,) also outlined the lack of compulsory assessment for child offenders older than 14 years of age, and the lack of educational facilities for children found not guilty of their offences. The feedback from this section establishes that, one needs to factor in the recommendations from the professionals conducting assessments/ working with child offenders with psychiatric disorders since presently, unrealistic deadlines, assessment tools and protocols are set in place which hampers the quality of services provided to child offenders with, and indeed without, psychiatric disorders.

As explored in chapter 4, the Child Justice Amendment Bill (2018) touched on the issues facing child justice practitioners in terms of conducting assessments on child offenders, these issues stemmed from a lack of resources, inadequacy of skills from

existing service-providers and inadequate time to conduct assessment on a large number of children, with limited service-providers. Although these concerns were raised in the Child Justice Amendment Bill (2018), the focus was placed on probation officer assessments and no attention was granted to issues experienced by psychiatrists or psychologists when assessing criminal capacity. Thus, the feedback in this section pertaining to the need for effective assessment practice to holistically assess the child, re-emphasises the aim of this study, which is to adopt a holistic approach when dealing with child offenders, in order to provide effective methods of practice which meet the best interest of the child in all areas of the child justice system.³⁰

In addition to the legislative ambiguities highlighted above, specific to the child justice legislation in terms of the criminal capacity assessment, Mr S Pillay (participant 10) outlined the following.

“The act hasn’t been written in a way where the taxonomy is consistent with what the DSM [5] or ICD [10] is” (Mr S Pillay: participant: 10).

This opinion is of particular significance to this study, since the legislative stipulation and criteria used to assess a child is unclear in comparison to the DSM-5 (2013) which provides a specific criterion that should be used for diagnostic purposes. The challenges identified in the literature, as well as in the feedback from the aforesaid opinion imply and reinforce that, presently child justice legislation provides room for interpretation from child justice practitioners. If legislation allows room for interpretation from each practitioner, there will not be standardisation in dealing with the child since each practitioner will adopt a different, unique approach, although they may be similar in terms of the DSM-5 (2013). It is essential that all children or all persons, who are assessed are assessed against the same criteria in terms of assessment tools and reporting protocol. This is of relevance to ensure that there is a specific criterion which is adhered to when dealing with children in conflict with the law.

The majority of participants (participant 2, 3, 10, 11, 22 & 24) who made legislative recommendations, touching on the need for clarity and improvements in the

³⁰ Refer to chapter 4, for detailed discussion of the assessment and the inadequacy of the current practice applied to child offenders with psychiatric disorders.

assessment procedures and a speedier child justice process, were of the opinion that, all legislative sections pertaining to child offenders with psychiatric disorders need to speak to each other and in order for a holistic approach to be adopted legislatively, a multi-disciplinary approach needs to be adopted to deal with child offenders with psychiatric disorders. This will create clear, inter-sectorial communications between all governmental departments ensuring that there are effective procedures implemented for the child, from the time the child enters into the justice system until he leaves.

In this regard, participants (participant 2, 3, 10, 11, 22 & 24) recommendations include increasing the age of criminal capacity; obliging all practitioners to assess child offenders older than 14 years of age for psychiatric disorders and cognitive and conative function, improvements in the criminal capacity assessment tool and time-frame, and the provision of educational facilities for child offenders found not guilty of an offence. In this light, the factors which caused the child to come into conflict with the child justice system will be addressed.

In contrast to the opinions expressed above which highlighted the inadequacies in the child justice legislation, some participants (participant 2, 17, 20 & 21) were of the opinion that the legislative framework utilised in South Africa is adequate, but the implementation thereof is poor and lacks dedication from governmental departments and service providers to implement and practice effectively.

“...In terms of policy, I think it’s good...if I compare where we are in terms of the rest of the world, in terms of policy we are actually doing very well... I think that we are failing with the implementation thereof...” (Mr B Viljoen: participant 21).

“...Legislation, in theory, is adequate, but the implementation behind it is the problem”. (Dr W Duncan: participant 17).

“I don’t think that we necessarily have a problem with legislation...but rather the implementation thereof is a problem” (Ms C Gould: participant: 20).

“The Act is sufficiently brought to allow practitioners who have an expertise in the field... to make recommendations on what is necessary...”

much like other aspects of SA, it's an implementation problem... (Dr S Omar: participant 15).

"...In order to cap this problem, it takes us back to the basics in that it takes the whole village to raise a child...so the implementation of so many acts has disempowered so many families. South Africa is a beautiful country we are fortunate to have so many legislations, but now we need implementation" (Ms E More: participant 11).

The overarching feedback from this section outlines that, the present legislation is adequate in addressing children in conflict with the law. However, the issues were identified in the implementation thereof in that; the methods of practice do not correspond with the stipulations in legislation in terms of dealing with children in conflict with the law.

Although it was established that the views of participants indicated that the legislation was adequate, these views do not correspond with literature identified in chapter 4 of this study as it has been outlined that the present inadequacies, such as applying the Criminal Procedure Act and Mental Health Care Act to determine the criminal responsibility of a child offender suffering from a psychiatric disorder, fails to specifically address factors which are unique to the child. It is inadequate/ incorrect to apply a legislative framework for adults to children since there are several factors which differ in terms of the psychological, emotional and moral development of the child, in comparison to that of an adult (Karels & Pienaar, 2015:60-61).

Legislative recommendations in this section reinforced the aim as well as met objective 1, 4 and 5, which focused on the need for a more individualised, case-specific approach to dealing with child offenders with psychiatric disorders. In addition, this section also highlighted child justice legislative recommendations, namely the increase of minimum age of criminal capacity, improvement in child justice legislation terminologies with clear definitions, the incorporation of one body of legislation which deals with all aspects pertaining to child offenders, instead of the current legislation which directs child justice practitioners to the Criminal Procedure Act.

In addition to these recommendations, participants (participant 2, 3, 5, 6, 12, 14, 15, 17, 22 & 24) also suggested the need for restorative justice, further implementation of diversion programmes, individualisation in treatment and mediation for children who come into conflict with the law. Furthermore, several participants (participant 6, 12, 15, 17 & 24) were of the opinion that, in order to meet the aforesaid recommendations, there needs to be an inclusion and collaboration in legislation whereby children who come into conflict with the law, and furthermore child offenders with psychiatric disorders, are dealt with in terms of one concise, holistic and clear legislative framework.

Stemming from the inadequacy of the child justice legislation the adequacy of role-players involved in the child justice process, namely child justice practitioners, came to the fore. In the section to follow, the adequacy of child justice practitioners will be explored in terms of if they are adequate in dealing with child offenders with psychiatric disorders in the child justice system.

- **The professionals that deal with child offenders with psychiatric disorders**

The contents of this section addressed the participants' views on the adequacy of professionals who presently deal with child offenders with psychiatric disorders.

Since the aim of this study is to recommend an improved trans-disciplinary, multi-dimensional framework of legislation and methods of practice that should be used to deal with children who come into conflict with the law; the adequacy of child justice practitioners was explored. As demonstrated in chapter 4 presently police officers, probation officers, psychologists, psychiatrists, legal representatives, and magistrates are involved in the child justice process.³¹

Similar to the findings from the section dealing with the adequacy of child justice legislation, the findings from this section linked with objective 1 of the study, and reinforced the studies aim. The findings in this section will be explored under 2 themes. The first theme will address the adequacy of child justice practitioners in the

³¹ Refer to the Child Justice Act sections 9, 12, 17-23, 26-28 for the role of the police officer; sections 5, 9-14, 19, 24, 28, 34-40, 43, 47-49, 57, 60-62, 67, 71-74, 76-79, 90, 97 for the role of the social worker and probation officer; for the role of the psychologist/psychiatrist see section 11; 13, 14, 22, 37, 41, 42, 43.

child justice system and the second theme will focus on recommendations pertaining to the current role-players in the child justice system.

- *The adequacy of child justice practitioners who deal with child offenders with psychiatric disorders*

Participants were asked if they thought that the present group of child justice practitioners, namely police officers, psychologists, psychiatrists, probation officers, social workers, and advocates, were adequate to holistically deal with child offenders suffering from psychiatric disorders. The feedback was as follows:

“...Definitely not... the individual approach means holistic approach, it means including everybody that can contribute to healing this child... and see to it that this child receives all the necessary interventions to deter him from criminal activities...so no the legislation is not adequate” (Ms M Human: participant 6).

“There is a lack of specialised training...legal practitioners also require further training. These children are not sympathetic or if they don’t behave in the way we want them to behave and often that counts double against you in the courtroom if sentencing or of decisions about care or any discretion... if you acting out in the courtroom, you will be punished harshly and so that’s why I feel there should be training for people dealing with these particular types of children” (Ms E Webber: participant 12).

“ ...At the end of the day, it’s become a very elitist group restricting it to these two professionals [psychologists and psychiatrists] because there are many other professionals who have strong grounding, training skills and experience who could also conduct criminal capacity...it’s very restrictive and least empowering... it should become most empowering and least restrictive [for child justice practitioners]” (Dr S Omar: participant 15).

“...We do not have people who work in the criminal justice system who have this [psychiatric disorder] level of knowledge” (Ms J Van Niekerk: participant 22).

Findings from this section indicate that in general, presently the current group of child justice practitioners are inadequate due to a lack of skills, lack of diversity in the actual professionals dealing with children in conflict with the law, and child offenders with psychiatric disorders. It was established that, the present group of child justice practitioners need further training in order to improve their skills and level of speciality and that there needs to be an inclusion of child justice practitioners from a multi-disciplinary approach, since the present group of practitioners lack basic skills and expert knowledge to provide effective treatment to the child. The recommendations pertaining to the further training, upskilling and the inclusion of further professionals will be outlined in sections below.

Further to the inadequacies of child justice practitioners highlighted above, participants also specified that South African police officers and probation officers lacked relevant skills in dealing with children in conflict with the law, and child offenders with psychiatric disorders. This feedback is emphasised below separately and is of relevance to this study since police officers are the first line of contact in dealing with a child who comes into conflict with the law. Secondly, the lack of skills identified from probation officers will also be highlighted since inadequate skills in the probation officer and social work sector will greatly hamper the services to child offenders with psychiatric disorders.³²

➤ ***Lack of skills police officers***

Participants, (2, 3, 8 & 11) were of the opinion that police officers lacked adequate knowledge, training, and skill to work with child offenders.

“...they have limited information [police officers] ... it is inadequate...if it was adequate, we wouldn't have the problems of sitting at intersectional committees arguing about one department [SAPS] is not doing things okay...” (Ms E More: participant 11).

“...The police are too polarised between the victim and the alleged perpetrator because it seems to me that they treat the alleged perpetrator as the guilty party, but they do not investigate properly” (Ms P Martin: participant 3).

³² Refer to chapter 4, on the duty of probation officers in dealing with children in conflict with the law.

“...we need more stringent provisions, reminding the police of their responsibility since they provide entrance to the system of justice and rehabilitation...and this is where we see the Child Justice system failing...where children are turned away...” (Ms J Van Niekerk: participant 22).

In this regard, challenges were identified, in that police officers were not following the legislated protocol pertaining to the assessment of children coming into conflict with the law or conducting their role in a case-sensitive manner by dealing with children in conflict with the law as a vulnerable group and furthermore performing their administrative tasks sufficiently. Hence the information that is available pertaining to the incidence of children coming into conflict with the law is inaccurate and is therefore not a true statistical reflection of the South African reality.

In addition to the inadequacies of the police officials, the inadequate skills and lack of specialised training for probation officers, who deal with children in conflict with the law, was a recurrent factor that many participants brought up (participant 2, 5, 6, 8, 9 & 13). It was interesting to note that probation officers shared similar concerns to that of the other child justice practitioners, pertaining to their own skills, expertise, and the requirements from the governmental departments in terms of their function in dealing with children in conflict with the law.

➤ ***Lack of skills for probation officers***

“...Probation officers do not have the speciality to do that...we [probation officers] may write one or two sentences and just touch on, but we are not experts, we cannot diagnose. You can say this information is reported, but it needs to be referred to psychiatrists or the specialists” (Anonymous: participant 9).

“...I’m also a bit concerned because they actually leave it to a probation officer to determine if there is a psychiatric disorder, and we are not trained to do that” (Mr B Collins: participant 8).

“...unlikely or limited because most probation officers conducting the assessment, usually are not very familiar with psychiatric issues...” (Mr M Batley: participant 5).

All probation officers and probation officer supervisors (participant 5, 8, 9 & 11) shared similar opinions, by indicating that, although probation officers do have an academic background of psychology, law, and social work, they have inadequate skills to conduct the large spectrum of assessments, recommendations and tasks required. In addition, there is a large caseload, and limited social workers and probation officers, which creates stress and poor service delivery. In this respect, specialised social work and probation degrees were suggested (participants 4, 6, 8, 9, 11, 12, 19 & 21). The issue pertaining to a lack of probation officers and social workers; and the large caseload of child offenders is a dire issue and was raised in the sections to follow. Furthermore, these issues, were also substantiated by research (Geoffrey, 2016: 177; Human, 2015:116) and documented in the Child Justice Amendment Bill (section 35 (g) and 40 (1) (f)) which outlines that, due to limited knowledge of probation officers they are not permitted to comment on the criminal capacity of child offenders. In this regard, the inadequacies of probation officers in the child justice system, general recommendations for improvement will be explored below.

- ***Recommendations- specialisation of professionals***

Following the discussion on the lack of skills of police officers and probation officers, the majority of participants (participant 4, 6, 8, 9, 11, 12, 19 & 21) were of the opinion that, overall there needed to be more skilled professionals, such as social workers, probation officers psychologists and psychiatrists, as well as advocates and magistrates, who are experts in child justice in South Africa. In this regard, the participants were of the following opinions:

“...Educating the politicians who are decision-makers in law...this is one of the biggest problems we have since it's not experts who make the laws, its politicians who make laws [and they lack knowledge]” (Ms J Van Nierkerk: participant: 24).

“...there should be an inclusion of a wider array of psychologists who have a better understanding of children in general, for example, educational and counselling psychologists ... [in the child justice system] (Professor G Pretorius: participant 24).

“In terms of the skills, there can always be upskilling. If there is standardisation you can actually look at what areas need to be assessed, but because there isn’t standardisation, it’s difficult to say whose lacking what...one person may have more experience in terms of child assessment...where as another may have more experience in terms of child development or intervention....There is always more space for more training...” (Mr B Viljoen: participant 21).

“...each profession needs to be adequately skilled to perform his or her task effectively. For example, in the CJA it refers to a psychologist or psychiatrists, but both are two very different roles. There needs to be a specification on each role and each has specialisation” (Mr S Pillay: participant 10).

“The field of child justice, whether victim or offender, should be a specialised field, within each profession...” (Ms J Van Niekerk: participant 22).

In concluding, the overarching opinion from this section was that, in order to holistically, effectively and adequately treat child offenders, and meet the best interest of this vulnerable group; in addition to the aforesaid legislative recommendations; there needs to be clear communication between all child justice departments and practitioners and a requirement for more skilled legal professionals, more skilled social workers and probation officers, more skilled and specialised medical practitioners and improved skills for police officers pertaining to language, sensitivity and restraint in dealing with child offenders with psychiatric disorders.

In addition to the up-skilling of current professionals in the child justice system, participants (participant 6 & 18) were of the opinion that, professionals, such as criminologists, victimologists and traumatologists needed to be included in the child justice process, especially in a South African context, due to the fact that the majority of child offenders are exposed to harsh and traumatic circumstances which influence their development of criminal behaviour (Neuman, 2015:1; World Health Organisation, 2015:1; Pelser, 2008:4; Cortina et al, 2012: 276-281; Trollip, 2014:1; Ntsabo, 2018:1; Geoffrey, 2016:111,16-167; Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk &

Karim, 2016:548-550).³³ The inclusion of specialist child justice practitioners is of relevance in providing holistic treatment for the child and it was established that there are very few skilled professionals in South Africa who have adequate knowledge and overlap between forensics, psychology, child justice and the law, to holistically deal with child offenders with psychiatric disorders. It must be identified that, when participants were asked whether criminologist should be included in the child justice process, the majority of participants were unaware of the role and function of a criminologist and could therefore not comment in this regard (participant 4, 5, 7, 8, 9, 10, 12, 13 & 17).

The overarching feedback from this section reinforced the aim of this study, which is to recommend a holistic, united, trans-disciplinary approach to deal with child offenders suffering from psychiatric disorders. A recommendation was also made that each child is designated a caregiver/guidance in the child justice process; this person need not be a highly qualified individual, but rather an individual who is able to guide and 'hold the child's hand' through the child justice process (participant 1 & 17). The need for clear communication between inter-sectorial governmental departments as well as the child justice practitioners was a recurrent recommendation. Recommendations were made pertaining to the up-skilling of all child justice professionals in terms of improving their knowledge specifically to children.

During the interviews, it was identified that a few medical child justice professionals lacked knowledge in the Child Justice Act, the best interest standard, and the availability of services to child offenders. This lack of knowledge is concerning since all practitioners involved in the child justice process should have adequate knowledge in these areas, and a lack thereof would result in injustice in services to this vulnerable group of children. Additionally, although the need for communication and a multi-disciplinary approach was recommended, contrary responses were also received from legal practitioners in that, as opposed to promoting a multi-disciplinary approach and inter-sectorial communication, the legal practitioners opinion reflected a lack of concern and willingness to create unity between governmental departments

³³ Refer to chapter 2, on the influence of negative environmental and socio-economic factors in a child's predisposition to come into conflict with the law.

that deal with child offenders with psychiatric disorders. The medical participants' opinions will be explored first followed by the legal opinion.

- ***Lack of skills***

In cognisance of the fact that a poor legislative knowledge and lack of concern will negatively affect children in the child justice system, in order to protect and respect the views of all participants, the comments in this section will remain anonymous.

"I wouldn't say worked on or improved on because I don't know exactly what the legislation says, but if it doesn't already say this, then there needs to be more attention on the social environment because when you look at the child's behaviour..." (Medical practitioner).

"I don't know if the Child Justice Act looks at the social environment that the child is coming from...and then also in terms of rehabilitation, I don't know if ...there is sufficient rehabilitation in terms for the child offender" (Medical practitioner).

"...the spirit of the law seems to suggest the best interest is important...but I'm hardly ever asked on best interest issues" (Medical practitioner).

"I know that there is a gap when it comes to services from talking to people, I don't know what the gap is in dealing with child offenders..." (Medical practitioner).

As mentioned, although the overarching feedback from this study emphasised the need for a holistic, multi-disciplinary and trans-disciplinary approach to dealing with child offenders and child offenders with psychiatric disorders, one legal participant was of the following opinion:

"...firstly, there must be services...how those services are presented, that is not the responsibility of the legal sector, that's the responsibility of the mental health sector" (Legal practitioner).

The lack of knowledge and concern, outlined in the aforementioned opinions raises concern since it is important to acknowledge that in order to improve on the child justice process, each child justice professional in terms of their attitude, willingness

and openness to develop, as a child justice expert, needs to be positive. With a common goal, namely meeting the best interest of the child, child justice practitioners may work in tandem to uphold the rights and improve the methods of practice used to deal with this vulnerable group of children.

Findings from this section clearly identified a lack of a multi-disciplinary, trans-disciplinary team and a lack of communication between the various experts and governmental departments in the child justice system. The ideology behind the best interest standard is to uphold the rights and to provide the best care and services to children, however, it is evident from the division, lack of skilled professionals, services, service providers and communication between child justice practitioners and departments, that each area is working in isolation and not in tandem with each other which hampers the services for children who are in the system and receiving services from these professionals and departments.

In addition to the legislation, and adequacy of child justice practitioners, the adequacy of services, or a lack thereof, was explored and will be addressed in the section to follow.

5.7 SERVICES AVAILABLE TO CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS

Factors pertaining to the services available to child offenders suffering from psychiatric disorders are of relevance to this study since literature, explored in chapter 2 and 3 of this study³⁴ reflected a lack of services available, from governmental departments, such as the DSD, DOJ&CD, DoE and DoH (Geoffrey, 2016; Bella et al 2010:1; Olashore et al, 2016; Heita, 2015; Olashore et al, 2017; Sommer et al 2017: 29-34; Paruk & Karim, 2016:548-550). Against this background, participants were asked if they thought the availability of services for child offenders with psychiatric disorders were adequate. The majority of participants (participant 1, 2, 3, 4, 6, 8, 9, 10, 12, 13, 15, 22 & 24) indicated that there were limited services available, and that service delivery needed to be improved on, from service-providers to facilities.

³⁴ Refer to chapter 3, on the lack of services available to child offenders with psychiatric disorders.

- **Service challenges**

"...when it comes about supply and demand and cost and how many assessments can be done, my concern is, are corners being cut, what is the quality, is it a bare minimum job? [due to limited service-providers and large caseloads] ..." (Mr B Viljoen: participant 21).

"...What always worries me is that those children who are not taken through the Child Justice System may well fall between the cracks and get lost, for those under 10 or 10 to 14... what actually happens to them? It's all well to say they shouldn't be criminalised, which is a concept I agree with, but with the same, some of them are really in need of some.... intervention and treatment... and I really don't know if sufficient attention is given to this" (Mr C Willows: participant 7).

"...They can't put in place laws if there are not psychiatrists and facilities and programmes...devoted to the kind of services that are needed...There are no services for anybody with that kind of profile [child offenders with disruptive, impulse-control, and conduct disorders]" (Professor J Sloth-Nielsen: participant 14).

"...what's happening is that kids who find themselves on the wrong side of the law seem to be dumped in psychiatric facilities because they are soft places and then once the psychiatric issue is managed there is nowhere for them to go..." (Dr W Duncan: participant 17).

"...Nothing gets done about them [children with psychiatric disorders or low IQ] ... not enough assessments, not enough placement, it all gets down to budget and those kids are at risk. There are not any services that I am aware of [that deals specifically with child offenders suffering from psychiatric disorders]. Our children are the future...the major resources should be going into the kids" (Ms P Martin: participant 3).

These opinions highlight the primary challenges for services to child offenders with psychiatric disorders, lack of facilities in the child justice system as well as a lack of psychiatric facilities, lack of specialised facilities and a lack of planning and implementation which currently hamper the quality of services to children who come into conflict with the law. Furthermore, it was also indicated that, although there are

current treatment protocols in place, the quality of services provided to child offenders with psychiatric disorders is poor due to a lack of service providers, or limited services providers with large caseloads.

In addition to the aforesaid, Ms P Martin (participant 3) provided opinion pertaining to systemic problems and a lack of services for the treatment of specific types of psychiatric disorders, such as CD.

“...there is virtually no organisation or institution in the country that deals with, treats takes in and assists adolescents with conduct disorder... nobody wants them because they are out of hand... and why are they out of hand ...” (Ms P Martin: participant 3).

“...because they live in that family system [poor familial structure exposure to violence, child malnutrition...]. So, you can't just treat the child, you need to treat the system (Ms P Martin: participant 3).

This opinion is of relevance to this study since it outlines that in order to treat a child who comes into conflict with the law, one needs to address more than just the child and in a sense of holistically treating the child, one needs to also factor in the influence of the family and therefore address issues and challenges experienced in the family which negatively affect the child. This opinion is similar to that which was highlighted by Professor T Lazarus (participant 19) which highlighted that the socio-cultural factors experienced by the child need to be taken into consideration since these are the primary factors which initially pre-disposed the child to developing problem behaviour.

An example of the systemic problem and a systems failure was expressed by Professor A Skelton (participant 1) in a case where a young boy, in a child and youth care centre, was diagnosed with CD, eating disorders, obesity and clinical depression. This child became violent when confined and would set fire to the hospital ward in which he was admitted. When caregivers at the child and youth care centre, and his parents, could not deal with the child, they turned to the criminal justice system in order to receive care or treatment since there were no alternative options and inadequate care for a child with CD. This, once again, proves the lack of expertise and services and the dire need for specialisation, not only in services but

also service-providers available to child offenders suffering from psychiatric disorders, such as ODD and CD.

Further to the opinions on the lack of services and service providers, an additional opinion on the need for specialisation in care and services for child offenders with psychiatric disorders in the criminal justice system was highlighted.

“...they [children suffering from ODD and CD] are sufficiently disorderly to warrant a different approach from the criminal justice system...”

(Professor J Sloth Nielsen: participant 14).

Although participants made recommendations pertaining to general services for child offenders with psychiatric disorders, Professor J Sloth-Nielsen (participant 14) highlighted an important factor since literature (Neuman, 2015:1; World Health Organisation, 2015:1; Pelser, 2008:4; Cortina et al, 2012: 276-281; Trollip, 2014:1; Ntsabo, 2018:1; Geoffrey, 2016:111, 16-167; Bella et al, 2010:1; Olashore et al, 2016; Heita, 2015:1; Olashore et al, 2017; Sommer et al, 2017: 29-34; Paruk & Karim, 2016:548-550) outlines that there is a high prevalence of child offenders with psychiatric disorders, such as ODD and CD, in the child justice system who require specialised services that pertain to the child's individual needs; and these services should be factored into the child justice system in order to deal with this vulnerable group of children from a case-specific perspective.

Findings explored earlier highlighted that due to limited time-frame children who manifested abnormal behaviour, and who may be symptomatic of psychiatric disorders, were not diagnosed. The feedback from the aforementioned participants in this section substantiated this finding in that both the medical and legal participants (participants 3, 8, 11, 12 & 15) indicated that sometimes, the influence of psychiatric disorders that are less noticeable, such as ADHD, LD, IDD, CD and ODD are not picked up and the child is labelled as naughty and dealt with in the child justice system, without adequate consideration granted to the impact the disorder has on the child's criminal capacity.

In addition to the challenges noted in the services available to child offenders with psychiatric disorders, participants provided their recommendations on how

improvements can be made in the child justice system and services to this group of children.

“...Understanding the problem and understanding the longer-term solutions, planning, budgeting, ensuring that there are preventative programmes that they don’t end up in the Child Justice System, but when they do that there are proper referrals systems for treatment” (Professor A Skelton: participant 1).

“...We need a multi-professional team which is based on the needs of the child...In a holistic assessment of the child... you need a holistic response to the needs of that particular child” (Ms J Van Niekerk: participant 24).

“I think that there is a huge need for better coordination between the different departments because part of the lack of provision and adequate care... there is lack of communication and strategizing between these departments which means that at some point the services to that child build huge gaps and that will fall short and they will end up the criminal justice system again. In order for it to work, it must work together as a whole...and that’s one of the major problems we have is that there is no talking between the experts on the different aspects of the child” (Ms E Webber: participant 12).

“...Early intervention on a clinic level, that these children or adolescents can be seen, prior to serious offences...especially with regards to those who have mental illnesses” (Mr B Viljoen: participant 21).

Recommendations made by the child justice experts’ highlighted pertinent factors to improve on the services available to child offenders with psychiatric disorders. These included, but were not limited to, a broader understanding of the issues facing the child, in order to prevent the child from entering into the child justice system, adequate services in the child justice system as well as after-care and child and youth care centres for the child, a multidisciplinary team of child justice professionals to deal with the child from a holistic perspective, adequate psychiatric services and facilities and the need for inter-sectoral communication to minimise the gap in service delivery between governmental departments and child justice practitioners.

In addition to the general recommendations made above for improvement on services to child offenders with psychiatric disorders, a recommendation was also made for awareness to be raised on the availability of services, types of services that are available and how to access the services since people are unaware of the services which may be useful to assist them and furthermore unaware of the availability of services for children with problem behaviour, or children in conflict with the law.

“The community does not know what services are offered. that brings us back to DSD...we are in an environment... we are informed but if you go to a ...smaller town, they are uninformed of what services are available and those children fall through the cracks” (Ms E Steenkamp: participant 16).

These recommendations outline the major areas where improvement is needed in the child justice system for improved service delivery to child offenders with psychiatric disorders.

In addition to the aforesaid recommendations, Dr P Maharaj (participant 2) and Professor A Skelton (participant 1) also indicated that, due to the time consuming nature of each assessment; cases ought to be filtered based on the type of offence committed, since children accused of minor offences, such as theft, require the same time and efforts as a child accused of a serious offence, such as rape. In this light, Dr P Maharaj (participant 2) indicated that minor offence related cases should enter into the justice system but rather be dealt with in terms of the child's needs, which influenced him to commit the offence. In this respect, trained professionals will be able to deal with serious offences; which warrant such effort, more adequately.

“...We could think of trying to priority fit so that we don't tie up our more skilled, more qualified people in cases where they don't need to be involved” (Professor A Skelton: participant 1).

In addition to the aforesaid recommendation pertaining to the assessment of the child, the delay from the time the child enters into the justice system, until the time the child is assessed was emphasised by the participants (participant 2, 3, 4, 10, 12, 13, 19, 20 & 21) as a major concern. In this regard, the aforementioned legal and

medical child justice practitioners indicated that the development and changes that occur whilst the child is awaiting an assessment, and further following the treatment thereof needs to be improved. This opinion is of relevance since literature provides further substantiation to the issues experienced in the child justice system due to the time delays and time constraints for the assessment of children in conflict with the law (Geoffrey, 2016: 177; Human, 2015:116). The argument here, from the majority of participants (participant 2, 3, 4, 10, 12, 13, 19, 20 & 21) was that, this time delay violates the child's rights in terms of section 3(f) and 80(d) of the Child Justice Act, which promises a speedy assessment, and also due to the changes and physical, emotional and psychological development that may occur, the child's needs will change and the treatment may therefore not be accurate.

Although there are several non-governmental organisations³⁵, such as Khulisa (2018:1), NICRO (2016:1), Young and in Prison (2016:1) and the Teddy Bear Foundation (2018:1), that specialise in dealing with children in conflict with the law, due to the large caseloads and limited funding, these NGO's are unable to provide effective services to all the children, who are need of such case (Geoffrey, 2016: 52-54).

It must be acknowledged that there has been development thus far in the availability of services for children in conflict with the law, in general, and child offenders with psychiatric disorders; however, feedback from the child justice experts reflects that there are still major areas of concern where further specialisation and services are needed.

The inadequate skills of existing child justice practitioners, inadequate service-providers, poor timeframes in the assessment process, referral process, placement for rehabilitation, educational facilities and specialised intervention programmes for children residing in urban and rural areas were outlined as major areas of concern. Furthermore, in terms of improved services, it was also indicated that a case-specific, holistic approach would include treating all factors which contributed to the risk of the child developing the psychiatric disorder and coming into conflict with the law- and not only addressing the factors around the criminal offence.

³⁵ Non-governmental organisation [hereafter referred to as NGO's]

The lack of services and poor skills that are presently available (or not available) to child offenders in the child justice system is a direct violation of the child's rights since legislatively, the child has the right to receive prompt and individualised treatment specific to mental health needs (South African Constitution (section 28), the Children's Act (section 9) & Child Justice Act)). In addition to a violation of the child's rights, South Africa has agreed to uphold the rights of the child and provide services, in lieu of her ratification of the UNCRC (1990, article 3(3),23(3-4)). Children are therefore victims of a multi-system failure from governmental departments which are supposed to provide specialised services to this group of children. This was highlighted in the literature explored in chapter 4 of this study (UNCRC, 1990, article 23 (1 and 3)).³⁶

In order to improve on and provide adequate services to this group of children, participants indicated that both long- and short-term planning is essential, in terms of finances, budgeting, skills and resources and community awareness of the availability of services. The development of these improvements can only materialise if there are inter-sectorial communication and development with all governmental departments working in tandem towards a common goal, which is to meet the best interests of the child.

The lack of child psychiatric facilities and the need for availability, especially for child offenders suffering from psychiatric disorders, was raised as another area of concern by the participants (participant 2, 3, 4, 5, 10, 12, 13, 19 & 20). These issues require dire attention since literature explored in chapter 3 of this study also outlined the lack of psychiatric facilities available for children in conflict with the law (Geoffrey, 2016: 172; Lund, 2018:1). Recommendations from all medical child justice practitioners (participant 2, 3, 7, 16, 17, 21, 22 & 24) as well as probation officers (participant 5, 8, 9, 11 & 13) included more specialised psychiatric services for this vulnerable group and the development of more residential care facilities, that are equipped to house child offenders suffering from psychiatric disorders, should there be a waiting period for psychiatric evaluation. Here, the aforementioned medical and probation officer participants indicated that child offenders are referred for inpatient psychiatric evaluation, but due to a lack of availability, get placed in a residential care facility.

³⁶ Refer to chapter 4, for discussion on the UNCRC (1990) and the rights of the child.

Since the residential care service-providers are ill-equipped to manage this group of children, the child gets removed and replaced several times, before being released into the community, up until a time that there is a psychiatric bed for the child.

In conclusion, participants indicated that, in order to improve on the specialisation of the child justice practitioners and to develop services, each governmental department needs to devise a sustainable funding plan, and then the implementation of thereof needs to be adapted. With this, in collaboration with the NGO's, and through regular assessments and research which measures the effectiveness of the services; each department will be able to continue, improve and reconstruct the services delivered to child offenders.

In bringing the themes discussed in this chapter together, namely the influence of psychiatric disorders, causative factors affecting the child, the inadequacy of the child justice legislation and the services available to child offenders, the final theme focuses on the best interest standard. The best interest standard is the overarching focus and purpose of the research study. Closely related to the adequacy of the child justice legislation and services available to this vulnerable group of children, is whether the current practice is meeting the best interest of the child.

5.8 THE BEST INTEREST STANDARD

The focus and outcome of this study all draw to meeting the best interests of children in conflict with the law, and more specifically child offenders with psychiatric disorders. This section stemmed from objective 6 of the study. Chapter 4 focused on the best interest standard in terms of the legislative framework and the criteria used to determine the best interests of children in conflict with the law.³⁷ Chapter 4, indicated that the best interest of the child is paramount in all matters, in practice this may not be the case at present.

After questions pertaining to the legislation and services for child offenders with psychiatric disorders were asked, participants were asked, if, in their opinion, the best interest of South African child offenders with psychiatric disorders are met. It must be acknowledged that many participants, both from the legal and medical field, were not knowledgeable about the best interest standard and it was found that they

³⁷ Refer to chapter 4, for a detailed discussion on the best interest principle.

were unable to provide a detailed opinion and suggestions or recommendations for improvement.

As outlined above, a lack of knowledge, specifically about the best interest standard is concerning since all child justice practitioners should have adequate knowledge since the South African child justice legislation (namely, Child Justice Act and Children's Act) is grounded on the best interest principle. If child justice practitioners have poor knowledge of the best interest standard, how then do these professionals aim to uphold the best interest of the child and furthermore determine the child's best interest in terms of treatment and referrals?

The feedback from participants will be explored under two sub-themes, namely '*Is the best interest of children in conflict with the law met?*' and '*Recommendations for meeting the best interest of the child*'.

- *Is the best interest of children in conflict with the law met?*

When participants were asked: "In your opinion, do you think the best interest of child offenders, as well as child offenders suffering from psychiatric disorders, are met?" The overarching feedback indicated that the best interests of the child are not met.

"Theoretically yes, I think legislation does try to look out for the best interest of the child, however, practically due to the lack of resources, I think it is not easily implemented" (Dr P Maharaj: participant 2).

"...As much as it's there in theory, the reality and application of the law often ...in terms of convenience ... it takes the system into account before it takes the child's needs into account... I don't think the resources has kept up with meeting the child's best interest..." (Dr W Duncan: participant: 17).

"...The law furthers the best interest, implementation and in practice... not so much..." (Dr S Omar: participant 15).

"...probably about 99.99 per cent of the children who come into conflict with the law are children who are victims and they have been let down by

the systems that are supposed to protect them and take care of their best interest...” (Ms P Martin: participant 3).

“Constitutional rights are being violated... it's a multi-systems failure...a health system that doesn't detect children with ...physical health problems, a primary healthcare system where people can't start seeing signs of psychiatric disorders and making appropriate referrals when referrals are made there is a shortage of places to go...there is nowhere to refer adolescents for inpatient treatment...This is their rights, under the state...they don't get an appropriate education for their age, abilities, disabilities...” (Ms P Martin: participant 3).

The general findings from this section emphasised that although legislatively it is stipulated that the best interest of the child is of paramount importance, in practice the implementation thereof is poor, and the child is repeatedly failed in the child justice system. Factors pertaining to a failure in meeting the best interest of the child, when referring to a multi-systems failure are reflected in the methods of practice, lack of service delivery, lack of skills for child justice practitioners, and overarchingly, the inability to address the needs of children in conflict with the law.

A prime example of the system not adhering to the obligations from international treaties and not making the effort to improve child justice legislation was demonstrated by the Child Justice Amendment Bill whereby legislation has been amended to accommodate the lack of skills from practitioners, such as the removal of the prosecuting officer from the responsibility to assess the cognitive abilities of the child, under section 10(a) of the Child Justice Act, as well as the removal of responsibility from probation officers to provide an opinion if expert evidence is needed in terms of the criminal capacity of the child (Child Justice Amendment Bill, section 35(g) and 40(1)(f)).

It is with this in mind that, in terms of 'aiming' to meet the best interest of the child, the question can then be asked, is amending legislation to suit the lack of skills from child justice practitioners a step in the right direction towards improving on the approach to dealing with this vulnerable group of children? Surely, this identification of a lack of skill and knowledge draws attention to the dire need for further skills and

training of child justice practitioners in the child justice system, instead of amending a legislative framework to suit the lack of skills from practitioners.

Since the study centres on adopting a multi-disciplinary, trans-disciplinary, holistic approach, to meeting the best interests of the child, chapter 4 focused specifically on the best interest standard in terms of legislative requirements as well as judicial interpretation.³⁸ In highlighting the issues pertaining to the best interest standard, participants also provided their opinions on general recommendations in order to meet the best interests of children, as well as children in conflict with the law.

- ***Recommendations for meeting the best interest of the child***

“...there should be room in the Children’s Act...in terms of the best interest of the child... I think we need to focus specifically on the best interest of the child offender as well...” (Professor G Pretorius: participant 24).

“I don’t think that you can work with a child in isolation from the family [this opinion provided that, when dealing with children who come into conflict with the law, one needs to approach the child holistically]” (Ms J Van Niekerk: participant 22).

“If you look at section 7 of the Children’s Act it sets out a range factors and certain cases have set out factors...but what’s good for child A may not be good for child B.... it needs to be case specific. The one thing the court has stressed is when assessing the best interest standard, one must look at the real precise life of that particular child and not something abstract... It’s an investigation of the real-life circumstances...” (Dr S Omar: participant 15).

“...We need to look at the bigger picture, not just instant and immediate... does this help in terms of long-term care ...and continuum of care? The best interest of the child should be a continuum of care” (Dr S Omar: participant 15).

³⁸ Refer to chapter 4, on best interest standard and judicial interpretation pertaining to the best interest standard for child offenders.

“...a child is a child and needs to be treated as a child... by meeting the best interest of the child is of paramount importance, by diverting the child, regardless of the nature of the offence, it empowers the child and the family because we are not only focusing on the child ...we look at the other elements which caused the individual to commit the offence” (Ms E More: participant 11).

“...Talking about the macro social policies that actually make the poor, which creates malnutrition, it creates inferior brain development, inferior health care...” (Participant 13: participant 13).

“...The family is absolutely key...The circumstances where they have come from and where they return to is key...” (Ms C Gould: participant 20).

The themes which emerged from this section outlined that in order to meet the best interest of children in conflict with the law, individualised child-care and case centred interventions need to be the focal point. Thus, in order to improve and to meet the best interest of child offenders with psychiatric disorders, as well as child offenders in general, one needs to focus on a macro-level, namely the circumstantial factors which cause crime and address that instead of focusing on a micro-level, namely why was this particular criminal offence committed. Here, the aforementioned participants recommended that factors to reduce and prevent criminal behaviour should focus on societal issues, environmental issues, and then the psychological issues which stem from the poor familial environment, substance abuse, child maltreatment, socio-economic deprivation and educational facilities.

In addressing macro-level issues, each department needs to assess the areas which are lacking and then address and implement systems which focus on their function and find durable solutions to long-term assist this vulnerable group of children in the long-term. In this respect, factors which prevent children from actually entering into the child justice system needs to be addressed rather than dealing with the child once in the system. This aspect also ties in with the aforesaid theme, and objective 4 of the study, which addressed the services available to child offenders with psychiatric disorders, or the lack thereof.

In addressing the child holistically, the emotional, moral, and social needs of the child can be addressed. In addition to meeting the best interest, Professor J Sloth-Nielsen (participant 14) and Ms E More (participant 11) were of the opinion that, it is also important to allow the child the responsibility to develop their moral and psychological maturity. With that, even though imprisonment should be avoided, consequences must be carried out as this, in the long-term, also aims to meet the best interests of the child. Here, balancing punishment with rehabilitation was highlighted. It was also suggested that looking at the most appropriate treatment for child offenders in order that they are most responsive to meet their best interest. This does not promise that the child will not be punished but rather ensures that the punishment suits the offence and also meets the long-term best interests long-term and develops adequate responsibility.

These recommendations are of significance and have also been substantiated in the documentation analysis, in chapter 4. In approaching the best interest standard from a holistic stance, both the short- and long-term needs of the child will be addressed and met. This will not only meet the best interest of the child who commits criminal offences, but also assures the best interest of society since measures will be taken to prevent the causes of criminal behaviour.

In conclusion, the overarching response from the child justice practitioners, regarding the availability of services and the best interest standard, was the need for a holistic, trans-disciplinary approach, which addresses the child on a multi-dimensional, multi-systems level; instead of the current practice which focuses largely on a medical model, which is a single-dimensional approach.

5.9 CONCLUSION

The findings from the data collection provide further substantiation for the literature explored in chapters 2, 3 and 4, by outlining the inadequacy of the present legislation and methods of practice used to deal with child offenders with psychiatric disorders.

Child justice practitioners had varied opinions on the categorisation of neurodevelopmental and disruptive, impulse-control, and conduct disorders, despite the fact that ODD and CD are clearly outlined in the DSM-5 (2013: 460-464) as diagnosable psychiatric disorders. Furthermore, a lack of standardisation in their

approach to assessment protocol and report writing was highlighted as an inadequacy that hampered service delivery to child offenders with psychiatric disorders.

In addition to this, literature explored in chapters 2, 3 and 4 explored the theoretical underpinnings, scientific diagnosis and categorisation of psychiatric disorders and analysis of child justice legislation and methods of practice, used to deal with child offenders with psychiatric disorders. Literature from the aforesaid chapters confirmed that the impact of poor socio-economic circumstances experienced by children residing in the African countries compared, increase their vulnerability and risk of developing psychiatric disorders and delinquent behaviour. An analysis of the legislative framework and methods of practice used to deal with this vulnerable group of children deemed it ineffective, inadequate and failing to uphold the best interests of child offenders.

The issues pertaining to violent living conditions and exposure to various harmful aspects in South African society were also brought to the fore as a contributory factor influencing the behaviour of children in conflict with the law. It was also reinforced that it is vital to take into consideration the context of the child, the context of the offence and the context of the tools used to assess and deal with this group. This is because many child offenders do not necessarily come from an urbanised or westernised social context and therefore do not always understand the norms and expected behaviour. Children who come from poor environmental contexts, who then come into conflict with the law are further brutalised by the system, which promotes the cycle of recidivism.

Factors pertaining to the attachment theory/the attachment disorder and the contextual circumstances of the child are of relevance since the aforementioned factors are found to directly affect child offenders, and particularly child offenders from African countries. Based on the findings from this empirical study, conclusions, and recommendations for a trans-disciplinary framework for dealing with child offenders with psychiatric disorders, will be explored in the chapter below.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS: TRANSDISCIPLINARY FRAMEWORK FOR DEALING WITH CHILDREN WITH PSYCHIATRIC DISORDERS WHO ARE IN CONFLICT WITH THE LAW

6.1 INTRODUCTION

The conclusions, inclusive of the proposed framework to uphold the best interests of child offenders with psychiatric disorders will be presented in this chapter. The conclusion, which informs and underpins the framework, emanates from the findings of the study, more specifically the document analysis and expert interviews. The chapter commences by indicating how the aim and objectives of the study were achieved; and will be followed by the key findings and conclusions. Based on the key findings and conclusions, the trans-disciplinary framework is presented. The chapter concludes with recommendations.

6.2 AIMS AND OBJECTIVES

The aim of this study was to develop a trans-disciplinary framework that can be used to deal with child offenders suffering from psychiatric disorders. Findings from the empirical data collection, namely document analysis and semi-structured interviews; were interpreted to address the research aim and objectives. In order to meet the aim of the study, the following research questions were identified, at the commencement of the study:¹

- What influence do environmental, social, cultural, psychological, and biological factors have on the child's brain development behaviour and predisposition to crime?
- Are the current child justice laws and methods of practice applied in South Africa effective in holistically dealing with child offenders with psychiatric disorders?

¹

Refer to chapter 1, for a discussion on the research methodology and research questions.

- What causative influence, if any, do psychiatric disorders, such as ADHD, IDD, LD, ODD and CD, have on the propensity towards criminal behaviour?
- What is the availability and efficacy of legislation and methods of dealing with child offenders with psychiatric disorders?
- Determine if the best interest standard is adequately met in dealing with child offenders with psychiatric disorders.

The research questions provided guidance for the development of the studies objectives. The aim of this study was achieved through the means of the following objectives.

6.2.1 Objective 1: analyse child justice legislation for child offenders with psychiatric disorders

Objective 1 was to analyse human rights, domestic and national child justice legislation used to deal with child offenders with psychiatric disorders in select African countries, namely Namibia, Botswana, Nigeria and South Africa, in order to determine if the existing legislation meets the best interests of the child. This aim was achieved by means of an in-depth literature review and documentation analysis in chapter 4, i.e. the first empirical phase of the study. In addition, this objective was further achieved during the data collection phase with child justice experts, presented in chapter 5 of the study.

6.2.2 Objective 2: explore psychiatric disorders, criminal behaviour and the influence thereof on children

The focus of objective 2 was to explore child justice experts' opinions on the definition and categorisation of neurodevelopmental and disruptive, impulse-control, and conduct disorders; the influence and prevalence of psychiatric disorders found in children in conflict with the law and the correlation between the severity of a psychiatric disorder and scheduled offences. This objective was achieved in a two-fold fashion. Firstly, by the in-depth literature review conducted in chapters 2 and 3 and secondly, from the data collection phase in chapter 5 of this study through the practical feedback from the child justice practitioners.

6.2.3 Objective 3: explore casual risk factors influencing psychiatric disorders in child offenders

In order to ascertain and establish factors which influence the development of psychiatric disorders and criminal behaviour, causative factors were explored. In objective 3 the influence of biological, psychological, social, and environmental factors which affect the child's behaviour, the development of psychiatric disorders and criminal behaviour were explored. In addition to these factors, this objective also focused on the influence of the aforesaid causative factors on brain development and the five developmental domains used to assess the criminal capacity of a child who is in conflict with the law. This objective was achieved by means of in-depth literature reviews, presented in chapters 2 and 3 of the study as well as under chapter 5, in the form of practical feedback from child justice practitioners.

6.2.4 Objective 4: analyse the availability of services to child offenders with psychiatric disorders

The exploration of the adequacy of services available to child offenders suffering from psychiatric disorders paved the way to identifying the need for a multi-disciplinary approach to dealing with child offenders with psychiatric disorders. This objective was achieved by means of literature explored in chapter 3 of this study and again reinforced in chapter 5, in the form of feedback from the child justice experts.

6.2.5 Objective 5: establish if the best interest standard for child offenders with psychiatric disorders are met

The best interests of the child are the focal point of this study. All 5 objectives in this study move towards meeting the best interests of a child in conflict with the law. This objective was achieved in the literature reviews, presented in chapters 2 and 3 of the study. In addition, this objective was furthermore achieved under both empirical data collection phases, presented in chapters 4 and 5 of this study.

It can be thus concluded the aim and objectives of this study were achieved.

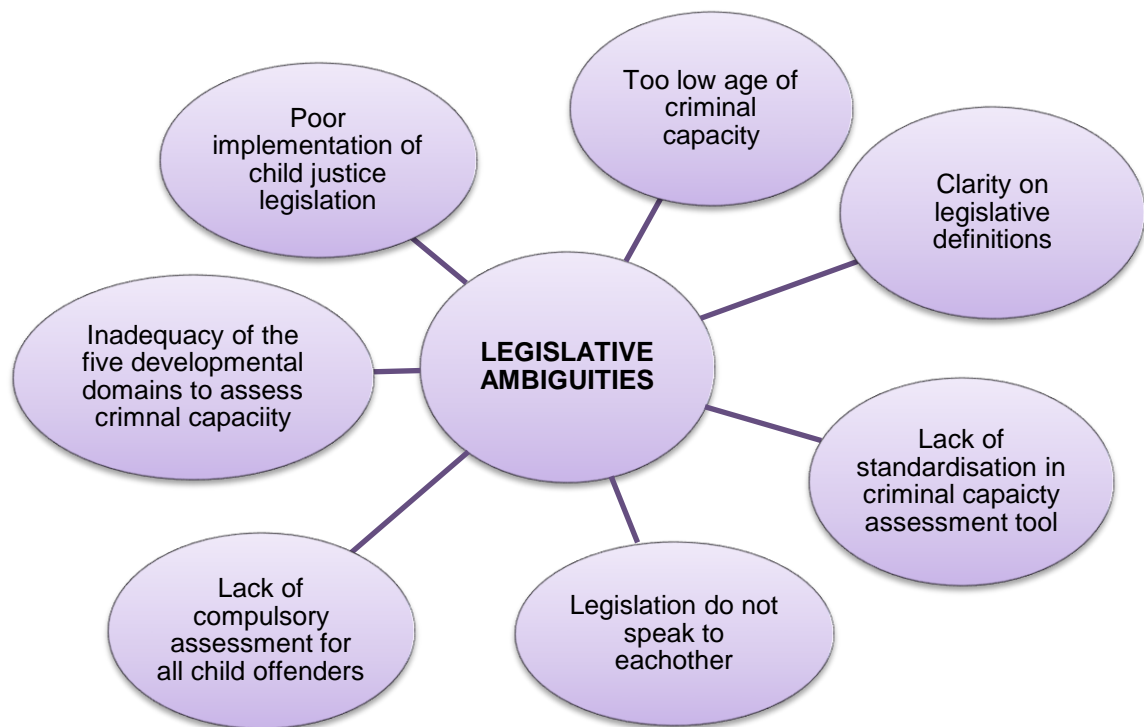
6.3 KEY FINDINGS AND CONCLUSIONS

The conclusions presented in this section emanated from the key findings which are integrated from the extensive literature reviews as well as both empirical data collection phases, namely the document analysis and semi-structured interviews.

6.3.1 Legislative ambiguities

Findings from this research confirmed that the child justice legislation used to deal with child offenders suffering from psychiatric disorders is inadequate in meeting the best interests of this vulnerable group of children. In this respect, the following legislative ambiguities were identified: a too low age of criminal capacity; lack of clear definitions in legislative terminology; lack of standardisation in assessment tool; an inadequacy of the five developmental domains to determine criminal capacity; lack of compulsory criminal capacity assessment for all child offenders under 18 years of age; poor implementation of legislation in terms of upholding the best interest of the child; and a lack of uniformity between the present child justice legislative frameworks, namely the Child Justice Act, Criminal Procedure Act, Mental Health Care Act and Children's Act, which do not function in tandem. Thus, the absence of specific child justice legislation that holistically deals with all factors pertaining to children, and children who come into conflict with the law, hampers the best interest standard.

DIAGRAM 9: Child justice legislative ambiguities



In general, it was established that, although legislation in the select African countries, does provide specific stipulation pertaining to the rights of the child and the legislative practice to deal with child offenders with psychiatric disorders; the implementation of legislation, methods of practice and services that should be afforded to a child were poor and therefore violated the child's basic rights.

It can therefore be concluded that, in order to improve legislatively: the minimum age of criminal capacity needs to be aligned with international human rights conventions, namely the UNCRC (1990), to 14 years of age; terminologies stipulated in legislation specific to child offenders with psychiatric disorders need to be clearly defined; a standardised assessment tool needs to be developed and implemented to ensure that all psychologists and psychiatrists are assessing the criminal capacity of a child against the same criteria; the five developmental domains used to determine criminal capacity need to be broadened in order to holistically assess the child; all children who come into conflict with the law need to be assessed for criminal

capacity (inclusive of child offenders 14 to 18 years of age); legislation should be correctly and effectively implemented in order to maximise the best interest standard of the child and legislation used to deal with children needs to be embodied under one primary legislative framework which addresses all factors pertaining to the child and children who come into conflict with the law, instead of the numerous different bodies of legislation that is currently used.²

6.3.2 African context

The existing legislative and practical framework used to deal with child offenders with psychiatric disorders is Eurocentric and does not take into account the African context, which needs to be revised and improved upon. Findings from this study emphasised the importance of addressing child offenders with psychiatric disorders, and children who come into conflict with the law from a holistic perspective, namely from a biologically, environmentally, psychologically, culturally and socially diverse approach. This is of importance since children residing in African may interpret social behaviour differently and are exposed to various negative socio-economic and familial issues, which directly influences the child's behaviour. The consideration of the aforesaid factors further ties in with the legislative suggestion to broaden the five developmental domains (and include specific socio-cultural practices) used to assess the criminal capacity of the child as well as the need for a multi-disciplinary approach in dealing with this vulnerable group of children, which will be highlighted below.

²

Refer to table 8 for tabulated child justice legislative recommendations that should be used to deal with child offenders with psychiatric disorders. These recommendations reinforce the need for an improved child justice legislation.

DIAGRAM 10: Uniquely African context



It can be concluded that in cognisance of the multifactorial issues which influence the brain development of the child, and in-turn influence problem behaviour, a holistic, multi-disciplinary and trans-disciplinary approach which considers the influence of biological, social, environmental, cultural and psychological factors, specific to an African context, should be adopted when dealing with child offenders with psychiatric disorders in a case-specific manner, in order to meet the best interest of the child. Furthermore, in adopting a holistic and multi-disciplinary approach, factors which are unique to an African context, in terms of cultural and socio-economic influences can be factored in when dealing with and ultimately treating a child who comes into conflict with the law.

6.3.3 Multidisciplinary approach

Findings suggest that the current group of child justice practitioners are inadequate to address and deal with all factors affecting a child offender with a psychiatric disorder, from a holistic perspective. This was established since it was identified that, in addition to the limited professionals used in the child justice system, some of the current group of child justice practitioners lack relevant knowledge and are therefore not adequately skilled in child justice or child mental health. Findings also established the scarcity in the availability of specialised services and the lack of inter-sectoral communication and integration between governmental departments and governmental departments and NGO's and child justice practitioners that provide services to children in conflict with the law and child offenders suffering from psychiatric disorders. Thus, children in conflict with the law and child offenders with psychiatric disorders are not receiving holistic, individualised treatment due to the mentioned inadequacies identified in the child justice services, service-providers and governmental departments.

DIAGRAM 11: Multidisciplinary approach to dealing with child offenders with psychiatric disorders

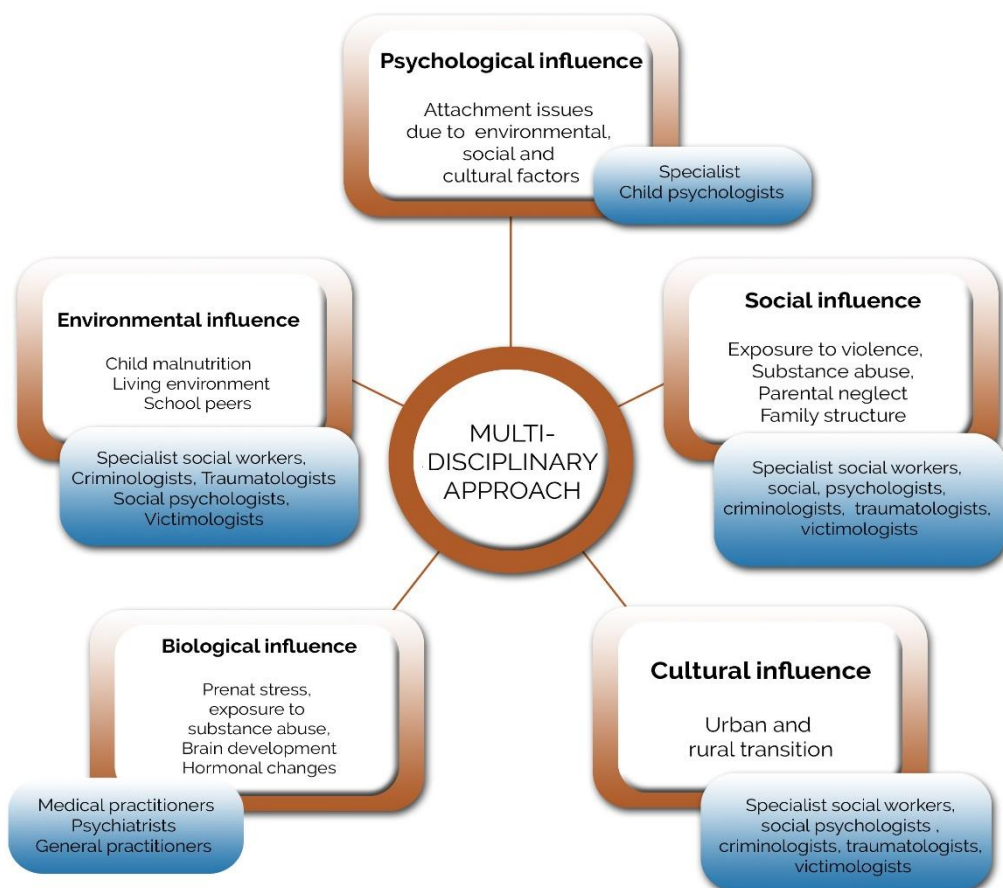


TABLE 8: RECOMMENDATIONS FOR THE INCLUSION OF CHILD JUSTICE PRACTITIONERS TO DEAL WITH CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS

ACT	SECTION	LEGISLATION	ROLE-PLAYERS	RECOMMENDATIONS
Child Justice Act	s11	(3) An inquiry magistrate or child justice court may, on own accord, or on the request of the prosecutor or the child's legal representative, order an evaluation of the criminal capacity of the child referred to in subsection (1), in the prescribed manner, by a suitably qualified person, which must include an assessment of the cognitive, moral, emotional, psychological and social development of the child.	Psychologists Psychiatrists	Criminologists Specialist social worker Specialist psychologist
Child Justice Act	s11 s40	(2) In making a decision regarding the criminal capacity of the child in question(a) the inquiry magistrate, for purposes of diversion; or (b) if the matter has not been diverted, the child justice court, for purposes of plea and trial, must consider the assessment report of the probation officer referred to in section 40 and all evidence placed before the inquiry magistrate or child justice court prior to diversion or conviction, as the case may be, which evidence may include a report of an evaluation referred to in subsection (3).	Social workers/ Probation officers	Criminologists Specialist social worker Specialist psychologist
Child Justice Act	s43	(2) The objectives of a preliminary inquiry are to(a) consider the assessment report of the probation officer, with particular reference to(i) the age estimation of the child, if the age is uncertain; (ii) the view of the probation officer regarding the criminal capacity of the child if the child is 10 years or older but under the age of 14 years and a decision whether an evaluation of the criminal capacity of the child by a suitably qualified person referred to in section 11 (3) is necessary; and (iii) whether a further and more detailed assessment of the child is needed as referred to in section 40 (1) (g);	Social workers/ Probation officers	Criminologists Specialist social worker Specialist psychologist

In order to ensure that this vulnerable group of children are dealt with by specialised experts in a multi-disciplinary context, it can be concluded that there needs to be an inclusion of a broader spectrum of specialised child justice practitioners; for example, criminologists, traumatologists, victimologists, and further training for specialised child, forensic, and social psychologists and psychiatrists; specialised child justice and mental health probation officers and social workers; and clear inter-sectorial communication within governmental departments, as well as between governmental departments and NGO's that provide services to child offenders suffering from psychiatric disorders.³

6.3.4 Differentiation in categorisation and diagnosis of psychiatric disorders

Findings from this study identified that there is a high prevalence of child offenders suffering from both neurodevelopmental (ADHD, LD & IDD) as well as disruptive, impulse-control, and conduct disorders (ODD & CD) and these disorders need to be taken into consideration when one is to determine the criminal capacity and treatment of the child offender.

Although both neurodevelopmental and disruptive, impulse-control, and conduct disorders are prevalent in child offenders; there is a differentiation in the categorisation of disruptive, impulse-control, and conduct disorders which results in children suffering from these types of disorders, namely ODD and CD, to receive lesser or limited services in the mental health care sector. In addition to the frequency of the aforesaid psychiatric disorders, namely ADHD, LD, IDD, ODD and CD; substance abuse, attachment disorder and foetal alcohol syndrome were highlighted as prevalence issues influencing problem behaviour for children in the selected African countries.

It can be concluded, as discussed that there is a high prevalence of child offenders manifesting with neurodevelopmental, disruptive, impulse-control, attachment and conduct disorders as well as substance abuse and foetal alcohol syndrome. The recognition of and attention to these disorders and syndromes in the form of specialised services, as demonstrated above, needs to be made available. In

³ Refer to table 8 and 9 for tabulated child justice legislative and practical recommendations that should be used to deal with child offenders with psychiatric disorders. These recommendations reinforce the need for a trans-disciplinary approach to dealing with child offenders with psychiatric disorders.

addition attention should be granted to the causative factors and treatment thereof for this group of children from all service providers.

Based on the key findings and conclusions resulting from this study, a trans-disciplinary framework to deal with child offenders with psychiatric disorders was developed.

6.4 A TRANS-DISCIPLINARY FRAMEWORK FOR CHILD OFFENDERS WITH PSYCHIATRIC DISORDERS

The primary aim of the framework is to establish a criterion that can be used to meet the best interest of children with psychiatric disorders, who come into conflict with the law. The conclusions from this study informed the proposed framework which was developed for improved legislation and methods of practice for meeting the best interest of child offenders suffering from psychiatric disorders.

- *Improve child justice legislation*
- *The multi-disciplinary approach in the child justice system in methods of practice*

DIAGRAM 12: Trans-disciplinary framework to deal with child offenders with psychiatric disorder

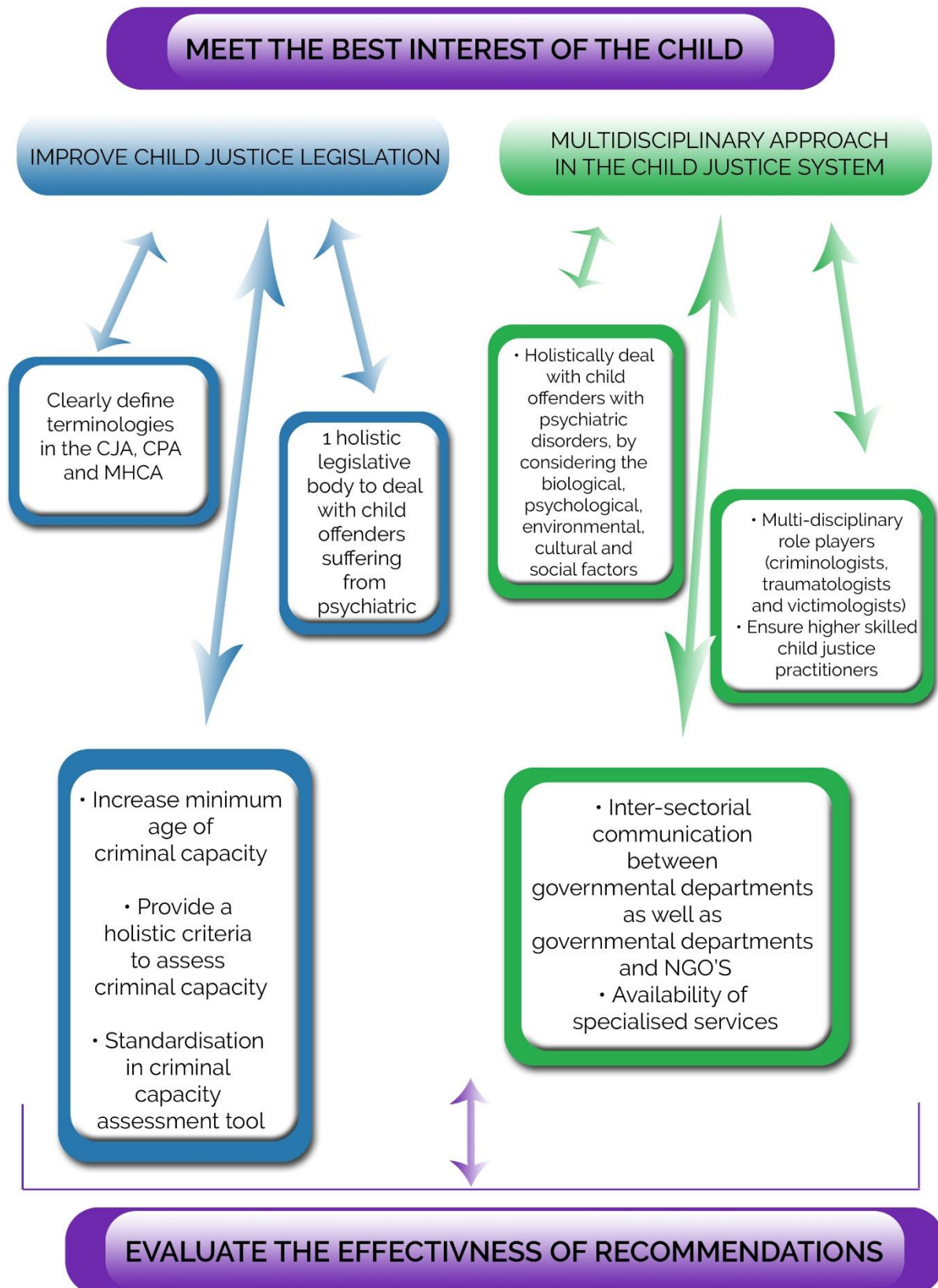


TABLE 9: LEGISLATIVE RECOMMENDATIONS FOR THE BEST INTEREST STANDARD

ACT	SECTION	LEGISLATION	RECOMMENDATION
Child Justice Act	s80	“ensure that the assessment, preliminary inquiry, trial or any other proceedings in which the child is involved, are concluded without delay and deal with the matter in a manner to ensure that the best interests of the child are at all times of paramount importance ; and”	<ul style="list-style-type: none"> • Case-specific • Individualised child care • Child-centered interventions • Real life issues • Familial factors • Treatment should provide aid and help for family • Psychological health • Treatment should focus on long-term rehabilitation
Children's Act	s9	“In all matters concerning the care, protection, and well-being of a child the standard that the child's best interest is of paramount importance, must be applied”.	
South African Constitution	s28	“A child's best interests are of paramount importance in every matter concerning the child”.	

As indicated in diagram 12, and echoed in table 9, the trans-disciplinary framework for dealing with child offenders with psychiatric disorders should factor in two primary components, namely (1) the improvement of legislation and addressing the aforesaid legislative ambiguities; (2) a multi-disciplinary approach pertaining to the methods of practice, role-players and services that are available in order to meet the best interest of the child.

Amendments, and the implementation thereof, in the identified areas of legislative ambiguity, used to deal with child offenders, would oblige all child justice practitioners as well as governmental and NGO's to deal with child offenders with psychiatric disorders from a case-specific approach which is grounded on the best interest of the child, both in legislation as well as in practice.

The inclusion of a broader spectrum of child justice experts and further skilled role-players in the child justice process will ensure that one field of professionals, or governmental department, would not be overburdened with the responsibility of large case-loads and limited resources, as presently experienced with social workers and probation officers in the child justice system. This will further ensure that children who come into conflict with the law are provided with diverse, expert, quality services in order to meet their best interest.

In meeting the best interest of the child, child justice practitioners need to adopt a holistic approach, which considers all factors which affect the child, on a multi-dimensional level, from a trans-disciplinary team of child justice practitioners. The single-dimensional practice approach repeatedly fails the child and due to a lack of resources and specialised service-providers, the child's right to receive services that pertain to his/her specialised needs in the child justice system is violated. In treating a child who comes into conflict with the law, and by holistically assessing the child, treatment needs to be provided holistically (socio-economic circumstances, familial circumstances, psychological circumstances and environmental circumstances). This type of approach would not only aid in addressing primary factors which cause criminal behaviour but also aid in reducing and preventing further recidivism for child offenders with psychiatric disorders. Thus, in meeting the best interest of the child, children will be dealt with from a multi-disciplinary team of professionals, who are experts in child justice and mental health in each sector of their speciality. In this

respect, multiple circumstantial and influential factors which cause problem behaviour and the development of psychiatric disorders will be factored in when dealing with child offenders with psychiatric disorders.

The framework is based on a step-by-step development and implementation of amendments in legislation and methods of practice. Each factor should be further evaluated in order to assess the effectiveness thereof in its implementation.⁴

6.5 RECOMMENDATIONS

The primary recommendation of this study is that the trans-disciplinary framework, as proposed in this study, should be implemented in dealing with child offenders with psychiatric disorders. In order to implement the proposed framework child justice experts, need to be cognisant of the multifactorial factors which influence the child in terms of their predisposition to coming into conflict with the law. Based on the awareness of each child justice expert, the governmental sectors need to further establish a multidimensional and trans-disciplinary systems approach, which incorporates the broad spectrum of child justice practitioners to deal with this vulnerable group of children.

The benefits of this implementation would be a step towards addressing the vulnerability and specific needs of the child in the child justice system and a positive attempt towards attempting to meet the best interest of the child with psychiatric disorders in the child justice system.

This can be accomplished by proposing the developed framework in the child justice systems. In cognisance of the developed framework, the integration and inter-sectorial communication between governmental and non-governmental departments that deal with child offenders with psychiatric disorders should be established in order to meet the best interest of the child.

The following final recommendations were made for this study.

⁴

Refer to tables 8 and 9 E tabulated child justice legislative and practical recommendations as well as legislative criteria that should be used to deal with child offenders with psychiatric disorders in order to meet the best interest of the child. These recommendations reinforce the need for a trans-disciplinary approach to dealing with child offenders with psychiatric disorders.

6.5.1 Further research

- A multidisciplinary inquiry should be conducted to address issues in child justice legislation to explore the multifactorial influences which predispose children to come into conflict with the law.
- An exploration of the neurological and neurobiological factors, in the presence of trauma, which influences criminal behaviour for children who come into conflict with the law should be explored. Research of this nature will provide further evidence to the factors that child justice practitioners should focus on when dealing with child offenders.
- An exploration of the DSM-5 (2013) and the ICD-10 (2015) should be conducted, in terms of the diagnostic criteria used to assess individuals who come into conflict with the law. In order to create standardisation for all psychologists and psychiatrists who conduct criminal capacity assessments, it is recommended that, findings from a study of this nature will add value to the development of criminal capacity assessment tools in terms of the criteria that should be used when dealing with child offenders with psychiatric disorders who come into conflict with the law.
- The underpinnings and application of the attachment disorder should be explored and applied to a South African context in terms of how this increases the child's risk of coming into conflict with the law.
- An evaluation of the effectiveness of the proposed amendments and methods of practice should be conducted in order to determine if the recommended framework is adequate to meet the best interest of child offenders with psychiatric disorders.

The afore recommendations which emerged from the empirical findings of this study all point towards further support in the aim and objectives of this study; which is to develop improved legislative and practical child justice and mental health procedures to deal with children from a holistic and case-specific approach. The effectiveness of the development and implementation of the afore recommendations will be analysed to decipher if and to the extent these changes are meeting the best interest of the

child. Thus child justice practitioners could make informed changes in aiming to further improve on the legislative and practical methods used with this vulnerable group.

6.6 CONCLUSION

The aim of the study was to develop a framework for improved legislation, methods of practice and services used to meet the best interest of child offenders with psychiatric disorders within the South African child justice system. It is evident from the literature explored in this study, as well as the empirical data collection that a change in the methods of approach in dealing with this vulnerable group of children, amendments in the child justice legislation as well as in the methods of practice are needed to improve on the current practice applied to children with psychiatric disorders in conflict with the law, in order to address the best interest of the child and deal with this vulnerable from a holistic approach⁵.

Both the literature explored in this study, and the empirical data collected, indicate that adopting a multi-disciplinary and holistic approach to dealing with child offenders with psychiatric disorders is a step in the right direction towards meeting the best interest of the child. It against this background that this study recommends the implementation of a trans-disciplinary framework which can be used to improve on the legislative framework, methods of practice and services available to child offenders with psychiatric disorders.

⁵ Refer to chapter 6 in this regard for a detailed discussion on the findings and recommendations made in this study.

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Participant 10- Mr S Pillay. Psychologist. 18/09/2018.

Participant 11- Ms E More. Probation officer supervisor. 21/09/2018.

Participant 12- Ms E Webber. Advocate. 26/09/2018.

Participant 13- Anonymous. Clinical psychologist. 03/10/2018.

Participant 14- Professor Julia Sloth-Nielsen. Professor of Law at the University of Western Cape. 01/10/2018.

Participant 15- Dr S Omar. Clinical director at the Teddy Bear Foundation. 02/10/2018.

Participant 16 - Ms E Steenkamp. Social worker at the Teddy Bear Foundation. 21/09/2018.

Participant 17- Dr W Duncan. Independent Child Psychiatrist. 25/09/2018.

Participant 18- Professor J Barkhuizen. Professor of Criminology at acting Head of Department of Criminology at the University of Limpopo. 03/10/2018.

Participant 19- Professor T Lazarus. Independent Forensic Psychologist and Professor of Psychology. 01/10/2018.

Participant 2- Dr P Maharaj. Psychiatrist in Forensic unit. 12/09/2018.

Participant 20- Ms C Gould. Senior Researcher for crime and justice programme at the Institute of Security Studies. 25/09/2018.

Participant 21- Mr B Viljoen. Clinical Psychologist. 28/09/2018.

Participant 22- Ms J Van Niekerk. Social Worker. 03/10/2018.

Participant 23- Ms Chabala. Criminologist and Lecturer at the University of Limpopo. 05/10/2018.

Participant 24- Professor G Pretorius. Psychologist and Professor at the University of Johannesburg. 29/10/2018.

Participant 3 - Ms P Martin. Independent Psychologist. 13/09/2018.

Participant 4- Anonymous. Advocate. 13/09/2018.

Participant 5- Mr M Batley. Probation Officer. 13/09/2018.

Participant 6 - Ms M Human. Criminologist and Academic. 14/09/2018.

Participant 7- Mr C Willows. Independent Psychologist. 17/09/2018.

Participant 8 - Mr B Collins. Probation officer supervisor. 18/09/2018.

Participant 9- Anonymous. Probation officer supervisor. 19/09/2018.

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ANNEXURE A: ETHICAL CLEARANCE



UNISA CLAW ETHICS REVIEW COMMITTEE

Date 20180411

Reference: ST38 of 2018

Applicant: LC Geoffrey

Dear Miss Geoffrey

**Decision: ETHICS APPROVAL
FROM 11 APRIL 2018
TO 10 APRIL 2021**

Researcher(s): Leandré Christina Geoffrey

Supervisor (s): Prof MJ Schoeman
Prof MG Karels

A trans-disciplinary approach to dealing with child offenders with psychiatric disorders

Qualification: PhD (Criminology)

Thank you for the application for research ethics clearance by the Unisa CLAW Ethics Review Committee for the above mentioned research. Ethics approval is granted for 3 years.

*The **low risk application** was reviewed by the CLAW Ethics Review Committee on 11 April 2018 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment. The decision was ratified by the committee.*

The proposed research may now commence with the provisions that:

1. The researcher will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the CLAW Committee.
3. The researcher will conduct the study according to the methods and procedures set out in the approved application.




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4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No field work activities may continue after the expiry date of 10 April 2021. Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number ST38 of 2018 should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.

Yours sincerely,



PROF N MOLLEMA

Chair of CLAW ERC

E-mail: mollen@unisa.ac.za

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PROF CI TSHOOSE

Executive Dean: CLAW

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ANNEXURE B: INFORMED CONSENT

INFORMED CONSENT LETTER

The University of South Africa

College of Law

Department of Criminology and Security Sciences

Researcher: Leandre' Christina Geoffrey

Title of study: A trans-disciplinary approach to dealing with child offenders with psychiatric disorders

Dear Participant,

My name is **Leandre' Christina Geoffrey**. I am doing research in the Department of Criminology and Security Science towards a Doctoral Degree in Criminology at the University of South Africa. You are invited to participate in a study entitled **A trans-disciplinary approach to dealing with child offenders with psychiatric disorders**.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to develop and recommend a trans-disciplinary approach which can be used to deal with child offenders, with psychiatric disorders. In this light, children suffering from psychiatric disorders, who come into conflict with the law, will be dealt with under specialised child justice legislation and methods of practice, which take into consideration the individualised needs and best interest of each child, from a case-specific perspective.

WHY AM I BEING INVITED TO PARTICIPATE?

You have been recognised as an expert, with experience in working with children who have psychiatric disorders and who are in conflict with the law.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

You will be required to participate in telephonic/skype or face-to-face interviews; that with your permission will be recorded.

The interview will be conducted using a semi-structured interview schedule, thereby creating an informal, flexible atmosphere to do an in-depth exploration of the research themes and other information relating to the research topic. The interview will focus on your perceptions, experiences and opinions about the legislation and methods of practice that is used to deal with child offenders with psychiatric disorders. The expected duration of the interview should not exceed 30 minutes. The guidelines for the semi-structured interview can be made available upon your request

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Your participation in this study is voluntary and you may withdraw from the study at any time. In the event that you may wish to withdraw participation, the data from your interview will be destroyed. The researcher and her supervisor will be the only individuals who will have access to the raw data from the interviews, thereby ensuring that the data will be treated as confidential and your anonymity will be ensured. With your permission, the interview will be audio-recorded. The recorded interviews will be transcribed and your responses (both audio and transcribed) will maintain anonymity and confidentiality. All identifying information will be deleted or disguised in any subsequent publication or presentation of the research findings.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no direct perceivable benefits for participating in this study.

However, it is foreseen that the findings from this study will assist with advocacy, add a valuable contribution to the scientific research community, and to child justice practitioners who deal with children with psychiatric disorders, who are in conflict with the law.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There are no perceivable risks identified in participating in the study. As highlighted above, all collected data and published findings will be done in a manner that supports the participants' confidentiality and anonymity.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

As mentioned, you have the right to anonymity and confidentiality if you participate in this study, unless you waive the right of anonymity by indicating that you wish to be identified in the study. Your name will not be recorded anywhere and no one, apart from the researcher and study supervisor, will know about your involvement in this research. The audio recorded interview and transcribed data (from your interview) will be given a code number or a pseudonym that will be used to refer to you in the report of all research findings. In addition, please note that the data from the research may be used for journal articles and/or conference proceedings. Your anonymity and confidentiality will be protected in a similar manner as in the original study.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

The audio recordings and hard copy of transcribed notes will be stored in a lock-up safety box for a period of five years, after which it will be destroyed. Electronic information will be stored on a password protected computer with a back-up of electronic information stored on a hard drive under an alias file name. Any future use of the stored data will be subject to further research ethics review and approval if applicable.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will be no incentives or payments made for your participation in the study. In addition, you, the participant will not incur any financial costs by participating in the

study. The acceptance of your participation will only require approximately 30 minutes of your time, as highlighted above.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the College of Law, UNISA. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

Findings from the study will be available online once the examination process of the thesis has been completed. If you would like to be informed of the final research findings or other information regarding the study, you are welcome to contact the researcher at the contact details listed below. Should you have concerns about the way in which the research has been conducted, you may contact Professor MI Schoeman (researcher's supervisor) on the contact details listed below. Alternatively, you may contact the research ethics chairperson of the UNISA Research Ethics Committee on the details listed below.

Researcher:

Name and surname: Leandre' Christina Geoffrey

Telephone: (+27) 723532479

Email: leigh.geoffrey@yahoo.com / 44281897@mylife.unisa.ac.za

Research supervisor:

Name and surname: Professor Marelize Schoeman

Telephone: (+27) 12433 9491

Email: schoemi@unisa.ac.za

College of Law Ethics Review Committee Chairperson:

Name and surname: Professor N Mollema

Email: mollen@unisa.ac.za

Thank you for taking the time to read this information and for participating in this study. I look forward to your most favourable response.

Leandre' Christina Geoffrey (Researcher)

INFORMED CONSENT FORM

Consent to participate in this study

I, _____ (participant name), confirm that the researcher asking my consent to take part in this research has told me about the nature, procedure, potential benefits, and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the audio recording of the telephonic interview/skype interview/face-to-face interview.

I have received a signed copy of the informed consent agreement.

I acknowledge that I was chosen to participate in the study because of my expertise in child justice. The views expressed are therefore my personal professional opinion and do not represent the views of the department of organisation I am employed at.

Please choose one of the options:

- I would like to remain anonymous and my identity not made known in the study
- I wave my right to anonymity and have no objections to my identity being made known in the study.

Participant name and surname:

Participant signature:

Date.....

Researcher's name and surname: Leandre' C Geoffrey

Researcher's signature

Date.....

ANNEXURE C: SEMI-STRUCTURED INTERVIEW SCHEDULE

Topic: 'A trans-disciplinary approach to dealing with child offenders with psychiatric disorders'

Researcher: Good Day, thank you for taking the time to participate in my study. This is a semi-structured interview and you are welcome to divulge into topics which I may have not discussed, that is relevant to the study. I will now commence with the interview.

Biographical information:

1. Are you involved in working with children/ child offenders/ children with psychiatric disorders?
2. What is your function in dealing with children/ child offenders/children with psychiatric disorders?
3. How many years of experience do you have in your field of speciality?

Psychiatric disorders and criminal behaviour:

4. How you do define a psychiatric disorder?
5. Do you view neurodevelopmental disorders, such as ADHD, LD and IDD as a psychiatric disorder?
6. Do you view disruptive, impulse-control, and conduct disorders, such as ODD and CD, as a psychiatric disorder?
7. As an expert/ practitioner in child justice, how often do you encounter children diagnosed with psychiatric disorders?
8. **Medical practitioners:** Do you think the influence of these disorders (ADHD, IDD, LD, CD and ODD) influence CC and should it be taken into consideration when assessing criminal capacity?

Medical practitioners: Do you think legal practitioners understand what a psychiatric disorder is and the influence this has on a child coming into conflict with the law?

9. **Legal practitioners:** Do you think clinical practitioners who conduct criminal capacity assessments have adequate knowledge on criminal capacity assessments and the factors which influence the criminal capacity?
10. Against the background of the researcher's master's study (reference can be provided if requested), the most prevalent psychiatric disorders found to influence child offenders included, ADHD, ODD, CD, LD and ID. In your experience, do you agree with these psychiatric disorders?
11. Are there any additional/other disorders that you wish to identify or remove from the aforementioned list?
12. In your opinion, to what extent do psychiatric disorders (as identified in the question above) influence criminal behaviour in children? Please provide examples of cases or your experiences if possible.
13. "The clinical concept (DSM) of a mental/psychiatric disorder provides a clear description in order for a clinical practitioner to make a diagnosis; whereas the legal concept of a mental /psychiatric disorder depends on the determination of the mental health practitioner in order to make a diagnosis." – As per section 1 of the Mental Health Care Act.
 - Do you think the current definition of what is viewed as a psychiatric disorder in accordance to the mental health care act influences the availability of services and the priority in caregiving to the children suffering from neurodevelopmental disorders? And then disruptive, impulse-control, and conduct disorders?

-

Causative factors influencing the development of psychiatric disorders and criminal behaviour:

14. Against the background of research (sources can be provided if required) biological, psychological, environmental and societal factors influence behaviour and the development of a psychiatric disorder.

- Do you agree with the aforementioned factors influencing the development of psychiatric disorders and criminal behaviour? YES/NO

Please elaborate on this answer

(Note to self: For example, what is your opinion on each factor and its influence on the child; In your opinion, are any specific factors more influential than others? Do you have any cases, or examples pertaining to your answer?).

15. To what extent do the aforementioned factors affect brain development? Greatly? Minimal, not at all?

If the participant answered greatly or minimally, how does brain development affect the following?

- criminal capacity
- criminality
- psychological development
- cognitive development
- emotional development
- social development
- moral development

Findings from research (chapter 4) indicate that, due to the symptoms of psychiatric disorders, such as ADHD, ODD and CD, namely impulsivity, poor self-control, inattentiveness, poor cognitive and conative function, this group of children are prone to criminal behaviour. Research (source can be provided) indicates that environmental circumstances influence criminal behaviour and risk of criminal

opportunity. Thus, as the symptoms of the disorder escalate, the severity the disorder is worsened.

16. Do you think there is a correlation between the severity of a psychiatric disorder (such as ADHD, LDD, IDD, ODD and CD) and the type of offences committed?

17. Do you think that there is a correlation between the severity of the disorder and the severity of offences committed?

Child justice legislation:

18. Presently, child offenders with psychiatric disorders are dealt with under the Children's Act, Child Justice Act and Criminal Procedure Act.

Medical practitioners: do you have knowledge of these legislative provisions?

19. If a psychiatric disorder is identified, do you take the influence of the psychiatric disorder as a factor which is considered relevant when assessing the child?

20. Do you feel that the current legislation applied to deal with child offenders with psychiatric disorders is adequate in holistically assessing all factors that could influence the child?

- Please elaborate on your answer.

21. How do you think current legislative practice can be improved in below: For example, assessment tools, time frame, follow up procedures and final reports?)

- Initial assessment
- Criminal capacity assessment
- Presentence assessment
- Rehabilitation assessment
- Recommendation for after-care

22. Child justice practitioners used to deal with child offenders with psychiatric disorders include social workers, probation officers, psychiatrist/ psychologists and advocates

- Do you feel that the current child justice practitioners are able to holistically assess all factors that could influence child offenders with psychiatric disorders?
- If no, which other experts do you recommend being included in child justice procedures and why?

23. Please outline any legislative recommendations/changes you would suggest for dealing with child offenders with psychiatric disorders?

Best interest standard:

24. In your opinion, do you think current legislation and methods of practice used to deal with child offenders with psychiatric disorders meets the best interest standard? / best interest of the child?

25. What aspects do you suggest should be assessed or focused on in order to meet the best interest of this group?

Services available to child offenders:

26. What services are available to child offenders with psychiatric disorders in the child justice system?

27. What services are available, pertaining to treatment and rehabilitation, to child offenders with psychiatric disorders once they leave the child justice system?

28. Please make recommendations for service delivery improvement for children in conflict with the law and child offenders with psychiatric disorders.

29. Do you have any additional areas of interest pertaining to the study that you wish to discuss?

Thank you for your participation in my study.

